Testimony before the United States House of Representatives
House Judiciary Committee
by
The Honorable Andrew Renzullo
Member of the General Court of the State of New Hampshire

Oversight Hearing on "The Reid-Kennedy Bill's Amnesty: Impacts on Taxpayers, Fundamental Fairness and the Rule of Law."
August 24, 2006
Concord, New Hampshire

My name is Andy Renzullo. I am a New Hampshire State Representative representing the towns of Hudson, Litchfield and Pelham. When I was asked to testify at this hearing I expressed concern as to what I could contribute to your understanding of the issue. I certainly do not have the expertise or data access Mr. Camarota has to speak to the fiscal impacts of illegal immigration. I do not have the experience or moral authority of Mr. Gadiel. What I am is a New Hampshire State Representative, which is a politically unique animal. I'm paid $100 per year. There are 400 of us, so I represent approximately 3250 people. I'm retired. I have a part time job where I talk to a lot of ordinary folks, working men and women. That's what I can contribute. They're upset with illegal immigration and are appalled at the Senate bill. They don't know what's fashionable or PC. They're not sure what's legal. But they are absolutely sure what's fair and what's right, and they usually know when they're being snookered. They don't want a "comprehensive" bill. The 1986 bill was a "comprehensive" bill. As Scotty said on a StarTrek Episode, "Fool me once, shame on you. Fool me twice, shame on me." Secure the border. We'll talk about what to do with the millions of illegal aliens already here once that's done.

When we look at the problem of illegal immigration and examine the published data, we find New Hampshire is fortunate to be less affected than other states, certainly less so than Arizona, Texas or California. But let's not be complacent. New Hampshire is still affected, especially with it's proximity to Massachusetts with an estimated 154,000 illegal aliens.[1] A state's illegal immigrant population can spike almost overnight. Look at South Carolina. In 1996 their illegal immigrant population was 4800 [2] while New Hampshire's was 2000 [3]. As South Carolina has about 3 times the population of New Hampshire, that's about an equal percentage. Jump ahead to 2005. The estimated illegal population in South Carolina is 76,000 vs 7000 in New Hampshire; that's a 1483% growth for South Carolina vs a 250% growth for New Hampshire. As New Hampshire's increase is less dramatic, the pain is less acute.

Let's look at a few issues and try to relate them to New Hampshire.

First some background:

New Hampshire has a population of 1.3 million. According to an April 2006 report by the Pew Hispanic Center, there are between 10 -30,000 "unauthorized migrants" in New Hampshire.[4] For any calculations we'll use the 10,000 estimate. It makes the math easier.

Does illegal immigration have any affect on public education in New Hampshire? In 2005 there were 205,767 pupils in New Hampshire public schools.[5] At an average per pupil expenditure of $11,186 per student, that's about $2.2 billion per year.[6] Part of that cost includes the 18.21% of children on reduced or free lunch programs[7] and the 1.24% of children in limited English proficiency programs.[8] According to a report by the Pew Hispanic Center,[9] in 2004 there were 13.9 million people in "unauthorized" families of which 3.1 million are citizen children of illegal aliens and 1.6 million are children illegally here. Using this formula and the 10,000 estimate of illegal residents mentioned previously, that would equate to 4350 pupils in New Hampshire as a result of illegal immigration (1481 illegally here and 2869 citizen-children whose parents are illegally here). That calculates out to $46.5 million dollars per year. Of course these numbers are estimates and extrapolations, because nobody asks the questions or collects any data! All that's required is proof that the child lives within the school district. Not good when the primary funding source for public education is the property tax.

What about medical care? One of the most irritating aspects of illegal immigration is the drain on our medical care system. Data shows that illegal aliens are twice as likely to use the emergency room, the most cost intensive of medical facilities. This is understandable as federal law requires emergency medical treatment. In New Hampshire, the uncompensated care cost was $237.4 million dollars in 2004, of which 116 million dollars were not Medicare or Medicaid underpayments.[10] That is what the 26 acute care facilities had to cost shift to everyone else in the state. How much is due to those illegally here. No-one knows! No one takes the data. In our politically correct society, no-one even dares ask the question. However, the anecdotal testimony is damning. On a recent radio program a well-respected public official told of a $200,000 medical bill at a Manchester hospital run up by an illegal alien. During testimony before the Municipal and County Government committee, I specifically asked a welfare administrator if public funds had gone to illegal aliens. He admitted as such, But again, no numbers. Nobody takes the data. Nobody dares ask.

And finally there's jobs. Why is it that many are outraged when jobs of middle class citizens are outsourced to foreign lands, but there is a poignant silence when those from foreign lands illegally come here to take the jobs of working class citizens? The nation's highest ranking public official says illegal aliens are coming "to do the jobs American's won't do." That's incorrect. Actually, it's jobs Americans won't do for the wages and working conditions being offered.

Who do you think is most directly hurt by the 10 to 20 million illegal immigrants flooding the labor market? It's the American worker at the lower end of the wage scale. It's the high school dropout who is trying to make it on the sweat of his or her brow. How

can the American worker hope to compete with those who are willing to work for lower wages and no benefits in an underground economy? And what happens to that American worker? Welfare, I guess.

To illustrate, New Ipswich, New Hampshire Chief of Police Garrett Chamberlain relates the story of his first encounter with the immigration issue. You might have heard of Chief Chamberlain. It was after this encounter, where the Immigration Service refused to collect the illegal aliens his department had encountered, that he made national news by trying to use the Trespass statute as a law enforcement tool to combat illegal immigration. A van was stopped for speeding. Hidden in the van were 10 illegal aliens from Ecuador who were doing roofing in Marlborough, New Hampshire, a nearby town. He learned they were being paid $180 for the day. Not each, ALL. That comes to $18 a day each. Not $18 per hour, but per day! That's $2.25 per hour (if you assume an 8 hour day). How can an American worker compete with that, and should he or she have to? And don't for a New York minute think that the lower labor costs were passed on to the consumer. And if one of the workers fell from the roof and was injured, who do you think would foot the medical bills other than the taxpayer? The point of the story is that the displaced American worker is on a downward slide toward public assistance.

These who oppose meaningful reform try to argue that it really only affects the agricultural industry. The data says they're wrong. A recent report put out by the Pew Hispanic Center[9] states that, in the United States, 27% of the drywall and tile installers, 22% of the cement masons and finishers, 21% of the roofers, and 19% of the bricklayers are here illegally. These are high paying union jobs.

Illegal immigration is one of those subliminal gut issues. It's not the type of thing that shows up in polls. Ask a New Hampshire citizen what are the most important issues facing the state and they will probably say taxes or health care or education funding. But, with God as my witness, I have yet to meet an ordinary working man or woman who isn't upset about the disregard of our borders and laws by our own government's lack of enforcement of those laws.

Thank you.

References:

[1,2,3] Extended Immigration Data for Massachusetts, South Carolina and New Hampshire. Prepared by the Federation for American Immigration Reform.

[4] Fact Sheet, April 26, 2006 Entitled: Estimates of the Unauthorized Migrant Population for States Based on the March 2005 CPS. Prepared by the Pew Hispanic Center.

[5] New Hampshire Department of Education. State Totals – Ten Years Public & Private Enrollments 1996-1997 through 2005-2006. Updated April 24, 2006

[6] New Hampshire Department of Education. State Average Cost per Pupil and Total Expenditures 2004-2005. Undated April 10, 2006.

[7] New Hampshire Department of Education. FY2005-2006 Free Reduced School Lunch Eligibility by District. Updated April 6, 2006.

[8] New Hampshire Department of Education. Students with Limited English Proficiency in Public Schools as of October 1, 2004. Updated April 5, 2005

[9] Unauthorized Migrants: Numbers and Characteristics. Background Briefing Prepared for Task Force on Immigration and America's Future. June 14, 2005. By Jeffrey S Passel for the Pew Hispanic Research Center.

[10] Cost Shifting in New Hampshire Hospitals 2004. Prepared by Douglas Hall for the New Hampshire Center for Pubic Policy Studies, February 2006.

ATTACHMENTS

Doing Research? : Immigration in Your Backyard

Extended Immigration Data for Massachusetts

Print this!
E-mail this!

Summary Demographic State Data (and Source)	
Population (2005 CB estimate):	**6398,743**
Population (2000 Census):	**6,349,097**
Foreign-Born Population (2005 FAIR estimate):	**935,655**
Foreign-Born Population (2000 Census):	**772,983**
Share Foreign-Born (2005 FAIR estimate):	**14.6%**
Share Foreign-Born (2000):	**12.2%**
Immigrant Stock (2000 CB estimate):	**1,708,000**
Share Immigrant Stock (2000 estimate):	**26.9%**
Naturalized U.S. Citizens (2000 Census):	**337,617**
Share Naturalized (2000):	**43.7%**
Legal Immigrant Admission (INS 1993-2002):	**223,930**
Refugee Admission (2001 HHS):	**1,969**
Illegal Alien Population (2005 FAIR estimate):	**154,000**
Projected Population - 2025(2001 FAIR):	**7,262,000**
Projected Population - 2050(2006 FAIR):	**10,663,863**

INDEX TO MASSACHUSETTS IMMIGRATION TOPICS

SOCIETAL ISSUES

A new study, *The Changing Workforce: Immigrants and the New Economy in Massachusetts,* has found that immigration is profoundly affecting the profile of the state's workforce. The report was compiled by

Professor Andrew Sum of Northeast University's Center for Labor Market Studies under the auspices of the Massachusetts Institute for a New Commonwealth (MassINC), a local think-tank for economic issues. MassINC's report provides a host of statistics on the shift of the state's immigrant population to one that is low-skilled, poor, and ill-adapted to its economy and society.

Some of Professor Sum's findings include:

- The majority of working-age immigrants to Massachusetts have only a high school degree or less. And in 1990, 41 percent of immigrant family householders lacked high school diploma or equivalent.
- Nearly 33 percent of immigrant households in the commonwealth were female-headed with no spouse present.
- Roughly 23 percent of all Massachusetts immigrant families lived below the poverty line (three times the rate of natives).
- Immigrant families account for 36 percent of all poor families in the state even though they are only 14 percent of the households.
- Immigrant families are also growing poorer relative to native families. In 1989, the median income for immigrant families in Massachusetts was 70 percent of the median income for native families; by 1997, it had dropped to 60 percent.
- 40 percent of the children in immigrant families live in poverty (compared to 11 percent for natives).

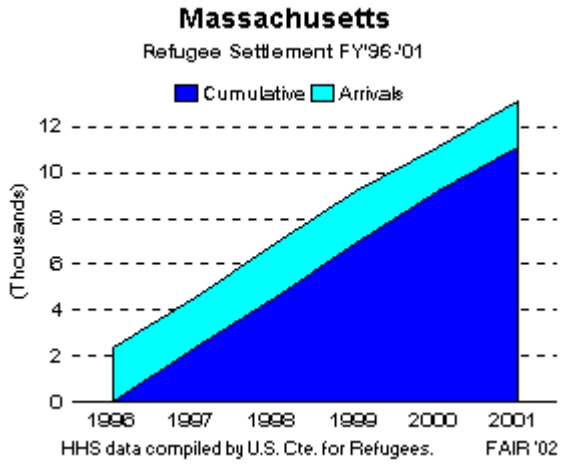
In addition to these purely economic indicators, the report mentions anecdotal evidence of the increasing disunity in Massachusetts society. These signs of demographic change appear in many forms and mediums:

- telephone company mailings that provide written communications and greetings in seven different languages;
- the appearance of a growing number of foreign language newspapers on the streets of Boston, Cambridge, Brookline, and even Newton;
- ads on the subways for English as a Second Language training by private schools and the recruitment signs for vocational training programs in five different Asian languages;
- the growing number of public service announcements and caution signs in Spanish and English;
- the increasing number of ethnic-oriented grocery stores and restaurants; and
- the large number of foreign students attending colleges and universities in the state, particularly the Greater Boston area.

The Changing Workforce can be ordered from the Massachusetts Institute for a New Commonwealth at its website, www.massinc.org.

Refugee Settlement
Massachusetts has received more than 13,100 refugees over the most recent six fiscal years (FY'96-'01) for permanent resettlement (1,969 in

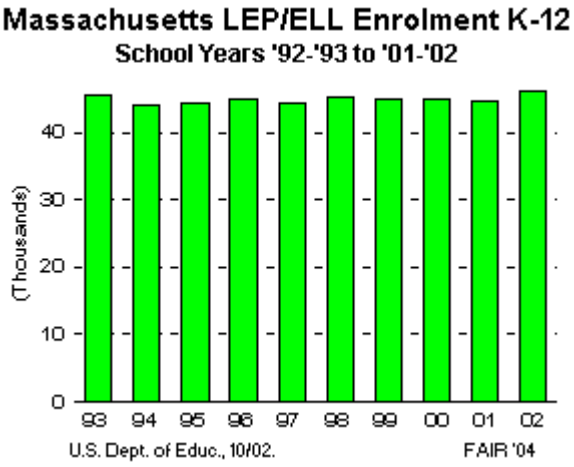
FY'01). This is an average of nearly 2,200 refugees per year.



Under the Office of Refugee Resettlement's (HHS) assistance funding for FY'02 $1,535,711 is available for refugee employment training and other services programs in Massachusetts based on a three-year refugee settlement program covering 6,119 refugees (an average of $251 per refugee). This allocation does not include a larger share (55%) of funding programs for communities heavily affected by recent Cuban and Haitian entrants, communities with refugees whose cultural differences make assimilation especially difficult, communities impacted by federal welfare reform changes, educational support to schools with significant refugee students, and discretionary grants.

LIMITED ENGLISH PROFICIENCY STUDENTS

Data are not available nationally on immigrant students (either legally or illegally resident in the United States) who are enrolled in primary and secondary schools (K-12). However, many of these students are enrolled in Limited English Proficiency/English Language Learning (LEP/ELL) instruction programs. Many may be U.S.-born, but the majority of these students may be assumed to be either immigrants or the children of immigrants, with the exception being areas with native Americans who speak a native language other than English.

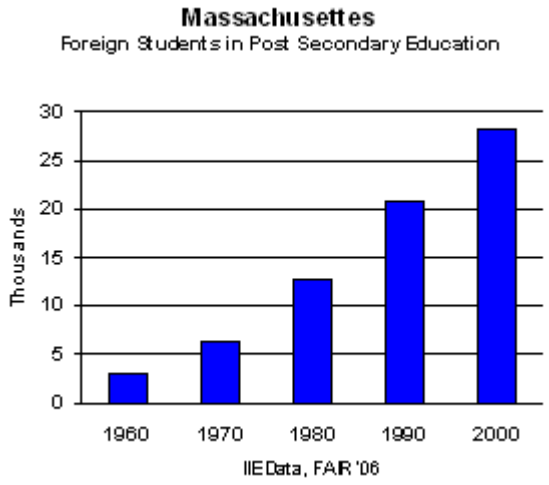


In Massachusetts, overall enrollment in 2002 (979,593) was 0.5 percent above enrollment in 1993. By contrast, LEP enrollment (46,078 - 4.7% of all enrollment) was 1.5 percent higher than a decade earlier.

Data on enrollment in LEP/ELL programs are collected by the federal government from school systems that receive Title VII funds for these special instruction programs. The data on LEP/ELL enrollment are understated because data from private schools that do not apply for Title VII assistance are sketchy.

FOREIGN STUDENTS

The 2004/05 annual report of the Institute of International Education (IIE) lists 27985 foreign students attending post-secondary school in Massachusetts. Several schools in this state are listed as having major concentrations of these students: Boston University (4,541 15.3%), Harvard University (3,546, 18.0%), Massachusetts Institute of Technology (2,723, 26.3%), Northeastern University (2,104, 8.9%) and University of Massachusetts at Amherst (1,724, 7.1%). The Boston MSA has the third largest concentration of foreign student of any MSA in the country.



For information on foreign student issues see: Foreign Students in the United States.

ILLEGAL ALIENS

The INS estimated in February 2003 that the illegal alien population in Massachusetts was about 87,000 residents. That was a slight increase above the last previous INS estimate that there were about 85,000 illegal alien residents in the state as of October 1996. The INS estimated that in October 1992 the resident illegal alien population was about 45,000 residents.

The most recent INS estimate meant that only 14 other states had higher numbers of illegal aliens residing in their states. Based upon the new 2000 Census data, the Migration Policy Institute issued a May 2002 study that estimated Massachusetts' illegal alien population at more than

100,000.

When the amnesty for illegal aliens was enacted in 1986, nearly 18,000 illegal aliens applied from Massachusetts for legalization.

Massachusetts has received partial compensation under the federal State Criminal Alien Assistance Program (SCAAP) that was established in 1994 to compensate the states and local jurisdictions for incarceration of "undocumented," aliens who are serving time for a felony conviction or at least two misdemeanors.

The recent SCAAP amounts that Massachusetts has received were:

FY'99—$25,909,882
FY'00—$14,921,282
FY'01—$10,548,800
FY'02—$13,121,495
FY'03—$7,949,202
FY'04—$6,991,154

The amount of SCAAP awards has been declining in both total distributions and even more as a share of the state's expenses. In FY'99 the state received 38.6% of its costs for 2,154 prisoner years of detention. By FY'02, the state's reported illegal alien detention decreased by 33 percent to 1,453 prisoner years, while compensation decreased by 49 percent, and then fell sharply.

MEDICAL COSTS OF ILLEGAL ALIENS

Under the Emergency Medical Treatment and Labor Act, hospitals with emergency rooms are required to treat and stabilize patients with emergency medical needs regardless whether or not they are in the country legally or whether they are able to pay for the treatment. Congress in 2003 enacted an appropriation of $250 million per year (for 4 years) to help offset some of the costs due to use of this service by illegal aliens. This amount has been allocated among the states based upon estimates of the illegal alien population and data on the apprehension of illegal aliens in each state. This amount compensates only a fraction of the medical outlays. For Massachusetts, the proposed payment in fiscal year 2004 is $2,074,682.

LOCAL ORGANIZATIONS

You can view a listing of local immigration reform organizations here.

STATE CONGRESSIONAL DELEGATION VOTING RECORD

You can view the voting record of your representatives in Congress regarding immigration issues in our voting report section.

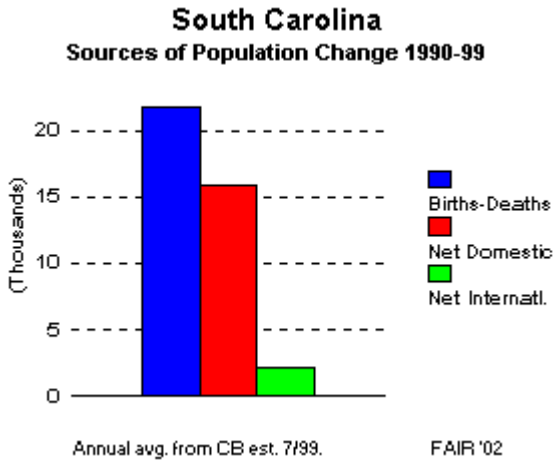
Extended Immigration Data for South Carolina

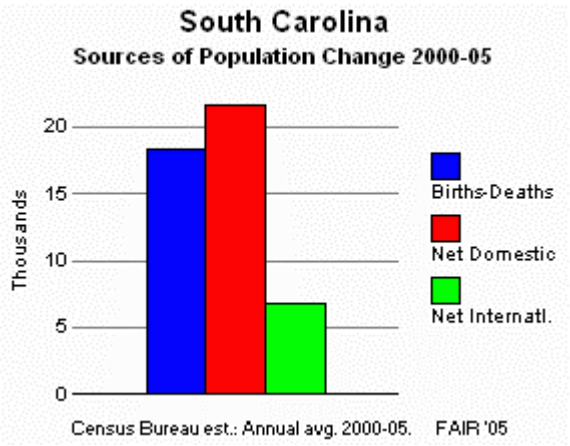
Summary Demographic State Data (and Source)	
Population (2005 CB estimate):	**4,255,083**
Population (2000 Census):	**4,012,012**
Foreign-Born Population (2005 FAIR estimate):	**152,380**
Foreign-Born Population (2000 Census):	**115,978**
Share Foreign-Born (2005 FAIR estimate):	**3.6%**
Share Foreign-Born (2000):	**2.9%**
Immigrant Stock (2000 CB estimate):	**131,000**
Share Immigrant Stock (2000 estimate):	**3.3%**
Naturalized U.S. Citizens (2000 Census):	**42,983**
Share Naturalized (2000):	**37.1%**
Legal Immigrant Admission (INS 1993-2002):	**23,080**
Refugee Admission (2001 HHS):	**85**
Illegal Alien Population (2005 FAIR estimate):	**76,000**
Projected Population - 2025 (2001 FAIR):	**5,698,000**
Projected Population - 2050 (2006 FAIR):	**6,373,401**

STATE POPULATION

The Census Bureau estimated that in July 2005 South Carolina's population had increased by an annual average of about 45,900 residents since 2000 (to **1,076,189** residents). Over that period net international migration (more immigrants arriving than leaving) was adding about 6,870 persons each year. During the same period there was an annual average population gain of about 21,715 residents from net domestic migration (more native-born residents arriving than leaving).

Net immigrant settlement accounted for about 15 percent of the population increase over this period, and that does not include the children born to the immigrants after their arrival in the United States. The current annual average level of immigrant settlement is about 233 percent higher than during the 1990s.



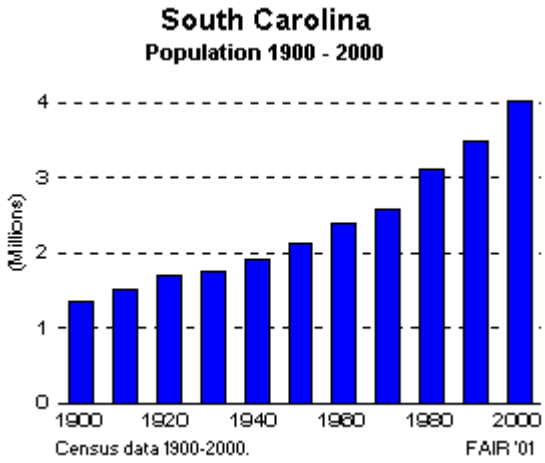


[Note: children born in the United States to immigrants (part of the immigrant stock) are no included as part of the immigration flow.]

The population of South Carolina increased by 11.7 percent between 1980-90 (from 3,120,729 to 3,486,703 residents).

The 2000 Census found 4,012,012 persons resident in South Carolina. This was an increase of 525,309 persons above the 1990 Census (15.1%). The amount of increase was the 19th highest in the country. The rate of increase was the 15th fastest increasing population in the country.

The 2000 population is about 54,000 more persons than the Census Bureau had expected to find in the state in 2000 when it issued its most recent state population projections in 1996. The significance of this is that the Census Bureau has concluded that much of the shortfall in their population estimates during the 1990s was due to an underestimation of the illegal alien population.



South Carolina had the 20th highest rate of population increase in the country between 1960-2000.

FOREIGN-BORN POPULATION

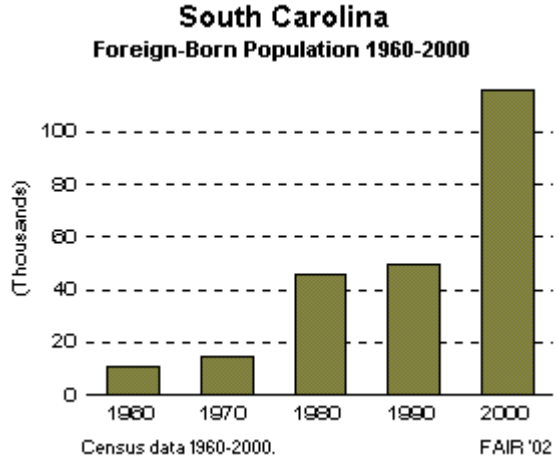
FAIR estimates that the foreign-born population of South Carolina was about 152,380 residents in July 2005. This meant a foreign-born population share of 3.6 percent. The amount of change since the 2000 Census indicates an average annual rate of increase in the foreign-born population of about 6,870 people, which is 15 percent of the state's annual average population increase. In addition, the Center for Immigration Studies recently estimated that 23 percent of babies being born in the United States are to foreign-born mothers. This share of the state's current births would be about 3,765 children born to immigrants in 2004-05, and the total share of population increase combining new immigration and births to foreign-born mothers would be about 23 percent of the state's overall population increase

The Census Bureau estimates that the foreign-born population share in South Carolina was 3.4 percent in 2003. This implies a foreign-born population of about 141,000 people. The amount of change since the 2000 Census indicates an annual rate of increase in the foreign-born population of about 7,600 people, which is 18.5 percent of the state's annual average population change.

The 2000 Census recorded 115,978 foreign-born residents in the state. That was 2.9 percent of the state's overall population and an increase of 132.1 percent above the 1990 foreign-born population of 49,964 residents. That more than doubling of the immigrant population was much higher than the 13.4 percent increase in the native-born population. The amount of increase was not among the 25 highest in the country, but the rate of increase in the foreign-born population was the 11th highest in the country.

A comparison of the increase in the immigrant population from 1990 with the change in the overall population during the same period shows that immigrant settlement directly accounted for 12.6 percent of the state's overall population increase over that decade. The share of the population increase due to immigration would be still higher if the children of the immigrants born here after their arrival were included with their immigrant parents in the calculation. The amount of the overall

impact of immigration on population change (immigrants plus their children) is more likely to account for about 16 percent of the state's population increase, based on the increase in the share of those who speak a language other than English at home in Rhode Island.



South Carolina ranked 6th nationally in the rate of foreign-born change between 1960-2000.

The 2000 Census found that 52.4 percent of South Carolina's foreign-born population had arrived in the state since 1990. This demonstrates the effects of the current mass immigration, and it is a much higher share than the national average (43.7%).

An indicator of the change in the immigrant population may be seen in data on the share of the population that speaks a language other than English at home. Between 1990 and 2000 the share of non-English speakers at home in South Carolina increased by nearly half, from 3.5 percent to 5.1 percent. Less than half (41.9%) of those who said they spoke a language other than English at home in 2000 also said they spoke English less than very well.

Speakers of Foreign Languages
(at home in South Carolina in the 2000 Census)

Spanish	110,030
French	19,030
German	15,195
Chinese	5,005
Tagalog	4,495
Vietnamese	3,770
Korean	3,295
Italian	3,090
Japanese	2,805
Greek	2,565

(Source: Census Bureau report: Language Spoken at Home for the Population 5 Years and Over, April 2004)

The immigrant population of South Carolina increased by 8.5 percent between 1980-90 (from 46,060 to 49,964 residents). The foreign-born share of the 1990 population was 1.4 percent (1.5% in 1980).

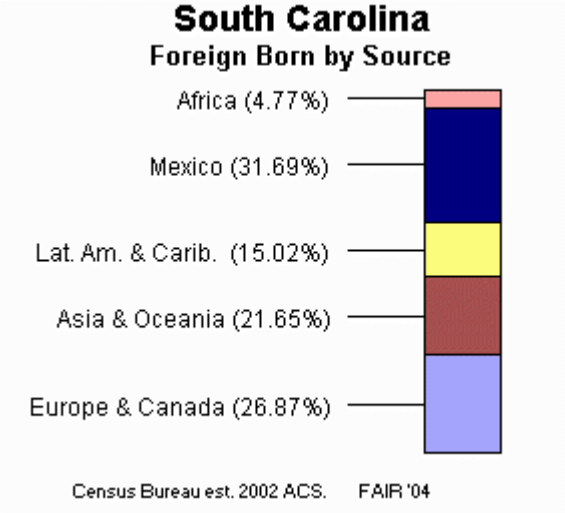
Foreign-Born Change Since 1980: Top Ten Countries 1980-2000

Rank	Country	1980	Country	1990	Country	2000
1	Germany	6,216	Germany	6,224	Mexico	31,719
2	U.K.	4,617	U.K.	5,130	Germany	7,873
3	Philip.	2,599	Philip.	3,429	U.K.	6,890
4	Canada	2,255	Canada	3,218	Canada	5,512
5	Korea	1,560	India	2,307	India	5,130
6	France	1,469	Mexico	2,147	Philip.	5,108
7	Japan	1,285	Korea	1,866	China *	4,541
8	India	1,192	Japan	1,665	Colombia	3,394
9	Greece	1,105	Vietnam	1,041	Vietnam	3,098
10	Sov.Un.	957	Greece	1,038	Korea	3,030
	All Others	22,825	All Other	21,899	All Others	39,683
	Total	46,080	Total	49,899	Total	115,978

* 2000 Census data for China include Hong Kong and Taiwan.

The ten countries above constituted nearly two-thirds (65.8%) of the foreign-born population in South Carolina in 2000. Persons born in Mexico alone accounted for more than one-quarter (27.3%) of the total foreign-born population. Compared to the 25,524 Mexican-born residents from the 2000 Census who said they entered the United States between 1990-2000, INS data (see below) indicate that the total number of legal Mexican immigrants who listed South Carolina as their intended residence during that period numbered about 3,300 persons.

The Census Bureau estimated from its American Community Survey that in 2002 the foreign-born population of South Carolina was about 138,500 persons. The chart below shows the regions from which those foreign residents came.

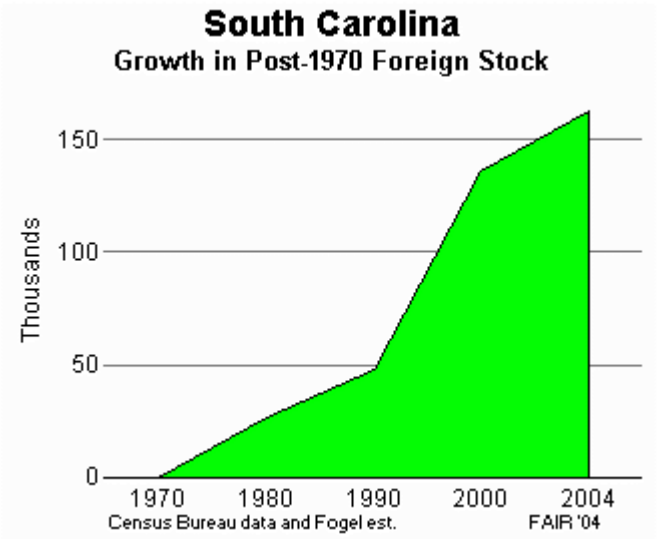


IMMIGRATION AND NATURALIZATION SERVICE DATA (Click here for data on immigrant settlement.)

THE IMMIGRANT STOCK

The 2000 Census recorded 131,000 people in South Carolina who were "immigrant stock." That is a term that refers to immigrants and their children born here after their arrival. Based on that estimate, and a population of 4,012,012, the immigrant stock share of the state's population was 3.3 percent.

As the graph below shows, the amount and share of South Carolina's population change due to the increase in the foreign stock is rising rapidly. Over the past 34 years the new immigrants and children born to them have added about 162,500 people to the population. Over this period, the increase in the foreign stock has accounted for 10.2 percent of the state's population increase.

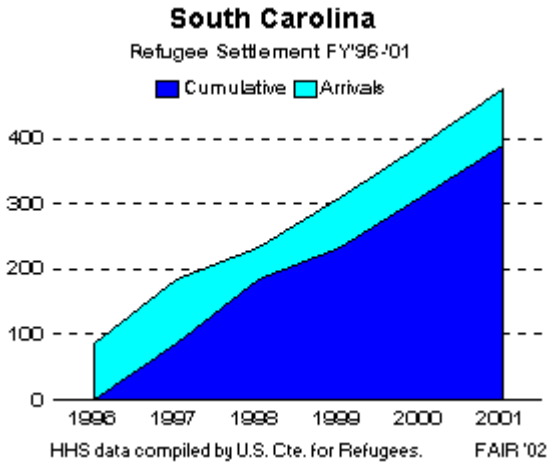


NATURALIZATION

Data from the 2000 Census recorded South Carolina's naturalized population at 42,983. That was a naturalization rate of 37.1 percent, lower than the national average of 40.1 percent. The precipitous drop in the rate of naturalization (see 1990 data below) indicates a rapidly increasing foreign-born population, including illegal immigrants.

Data from the 1990 Census showed that 50.9 percent of South Carolina's 49,964 foreign-born residents had become naturalized U.S. citizens. This was much higher than the national average (40.3%).

Refugee Settlement
South Carolina has received over 475 refugees over the most recent six fiscal years (FY'96-'01) for permanent resettlement (85 in FY'01). The average has been nearly 80 refugees per year.



Under the Office of Refugee Resettlement's (HHS) assistance funding for FY'02 $96,932 is available for refugee employment training and other services programs in South Carolina based on a three-year refugee settlement program covering 237 refugees (an average of $251 per refugee). This allocation does not include a larger share (55%) of funding programs for communities heavily affected by recent Cuban and Haitian entrants, communities with refugees whose cultural differences make assimilation especially difficult, communities impacted by federal welfare reform changes, educational support to schools with significant refugee students, and discretionary grants.

SOCIAL ISSUES

The Hispanic population in South Carolina is growing about six times faster that the state's overall population. Most of this increase is from immigration. Part of the explanation for this rapid change is the "population pipeline" between the communities in the sending country and the receiving country, and in part it may be due to large families. Mike Scardaville, a professor of Latin American studies at the University of South Carolina, estimates that the Hispanic growth rate is still higher because minorities and illegal aliens are undercounted and there has been an increase in the flow of newcomers. He estimates the Hispanic population to now be at least 150,000 compared to the 30,600 found in

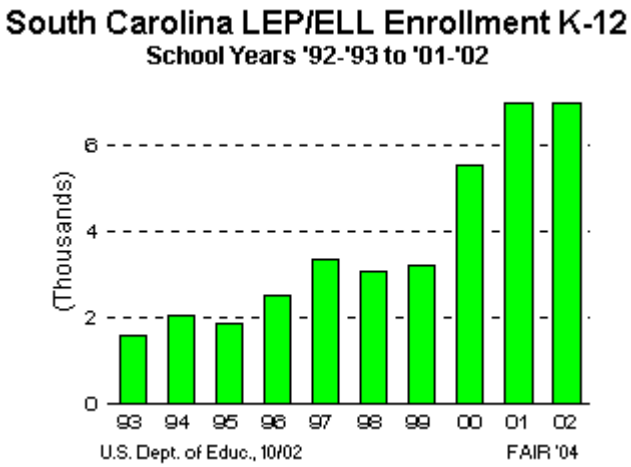
the 1990 Census.

One of the result of this rapid population change is that public employees in places such as Newberry are finding themselves in the unexpected position of studying Spanish to be able to provide services, from marriage licenses to medical and welfare services, to the newcomers. Although many of the arriving Hispanics may be legal residents or even U.S. citizens, others are illegal aliens attracted by low-skilled jobs and the absence of an INS office. However, a change may be taking place as a result of the opening of a new INS office in Charleston. According to Jose Monge, an immigration attorney in Columbia, "It's going to get hot."
(Source: *The State* (Columbia), April 18, 1998)

The influx of hundreds of immigrants to Greenwood to work at Greenwood Packing in 1994 unleashed a scramble among service providers to cope with the new situation. There were some early tensions with the city's minority black population over what was seen as job competition. The police chief says that tensions have now subsided, but local residents dispute that. The local school gained 23 Spanish-speaking children overnight. Health care providers couldn't communicate with the new patients. The local Job Service office has required non-English speakers to bring interpreters with them, but there were few bilingual persons in the area, and they became over-burdened. The labor contractor who recruited the Hispanic workers in Texas, provides them sub-standard housing for free. The meat processing employer is attacked by many of the workers for taking advantage of non-English speaking employees. According to one employee, "They only want people who will keep their mouths shut. If you defend yourself, they don't want you."
(Source: *The State* (Columbia), April 18 and 26, 1998)

LIMITED ENGLISH PROFICIENCY STUDENTS

Data are not available nationally on immigrant students (either legally or illegally resident in the United States) who are enrolled in primary and secondary schools (K-12). However, many of these students are enrolled in Limited English Proficiency/English Language Learning (LEP/ELL) instruction programs. Many may be U.S.-born, but the majority of these students may be assumed to be either immigrants or the children of immigrants, with the exception being areas with native Americans who speak a native language other than English.

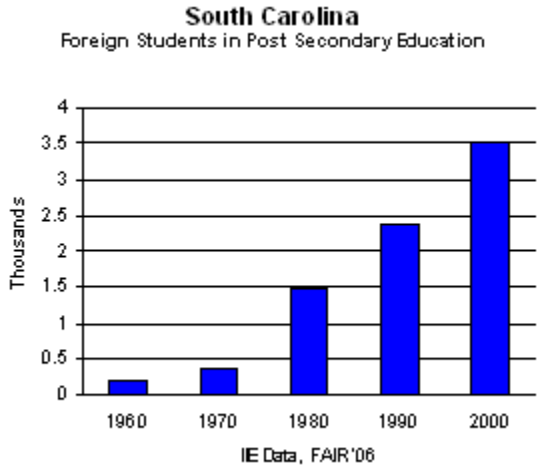


In South Carolina, overall enrollment in 2002 (648,000) was 5.9 percent below enrollment in 1993. By contrast, LEP enrollment (7,004 - 1.1% of all enrollment) was 339 percent higher than a decade earlier.

Data on enrollment in LEP/ELL programs are collected by the federal government from school systems that receive Title VII funds for these special instruction programs. The data on LEP/ELL enrollment are understated because data from private schools that do not apply for Title VII assistance are sketchy.

FOREIGN STUDENTS

The 2004/05 annual report of the Institute of International Education (IIE) lists the number of foreign students attending post-secondary school in South Carolina as 3,559. Below, a chart illustrates the sharp increase of foreign students attending school in South Carolina from 1960-2000.



For information on foreign student issues see: Foreign Students in the United States.

ILLEGAL ALIENS

The INS estimated in February 2003 that the illegal alien population in

South Carolina was about 36,000. That was almost eight times the previous INS estimate that there were about 4,800 illegal aliens residing in the state as of October 1996. The latter estimate was 17 percent higher than the estimate of the number of illegal aliens in October 1992.

South Carolina has received partial compensation under the federal State Criminal Alien Assistance Program (SCAAP) that was established in 1994 to compensate the states and local jurisdictions for incarceration of "undocumented," aliens who are serving time for a felony conviction or at least two misdemeanors.

The recent SCAAP amounts that South Carolina has received were:

FY'99—$1,029,751
FY'00—$873,493
FY'01—$889,885
FY'02—$963,588
FY'03—$298,985
FY'04—$432,428

The amount of SCAAP awards has been declining in both total distributions and even more as a share of the state's expenses. In FY'99 the state received 38.6% of its costs for 189 prisoner years of detention. By FY'02, the state's reported illegal alien detention rose by 71 percent to 324 prisoner years, while compensation fell by six percent and since has decreased rapidly.

MEDICAL COSTS OF ILLEGAL ALIENS

Under the Emergency Medical Treatment and Labor Act, hospitals with emergency rooms are required to treat and stabilize patients with emergency medical needs regardless whether or not they are in the country legally or whether they are able to pay for the treatment. Congress in 2003 enacted an appropriation of $250 million per year (for 4 years) to help offset some of the costs due to use of this service by illegal aliens. This amount has been allocated among the states based upon estimates of the illegal alien population and data on the apprehension of illegal aliens in each state. This amount compensates only a fraction of the medical outlays. For South Carolina, the proposed payment in fiscal year 2004 is $858,489.

LOCAL ORGANIZATIONS

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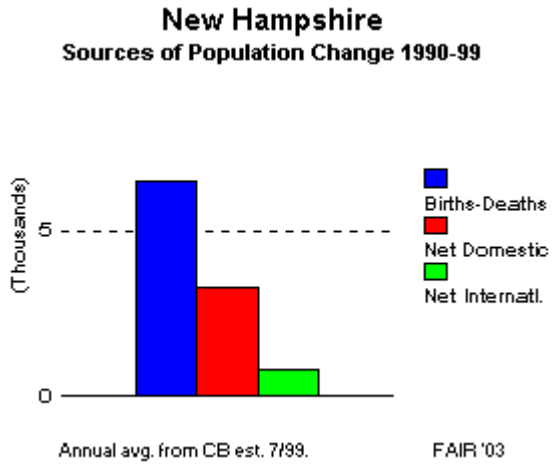
Extended Immigration Data for New Hampshire

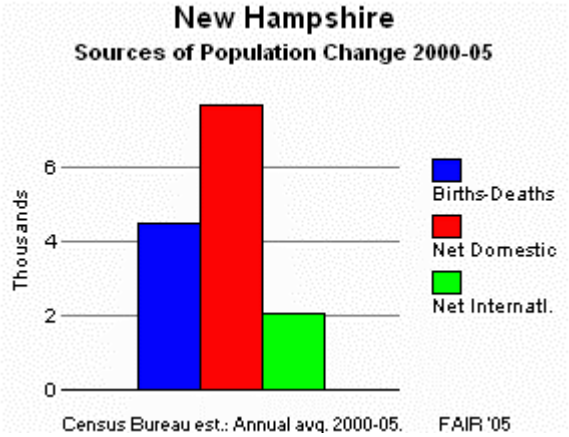
Summary Demographic State Data (and Source)	
Population (2005 FAIR estimate)	**1,309,940**
Population (2000 Census)	**1,235,786**
Foreign-Born Population (2005 FAIR estimate)	**65,260**
Foreign-Born Population (2000 Census)	**54,154**
Share Foreign-Born (2005 FAIR estimate)	**5.0%**
Share Foreign-Born (2000)	**4.4%**
Immigrant Stock (2000 CB estimate)	**174,000**
Share Immigrant Stock (2000 estimate)	**14.1%**
Naturalized U.S. Citizens (2000 Census)	**25,761**
Share Naturalized (2000):	**47.6%**
Legal Immigrant Admission (INS 1993-2002)	**15,862**
Refugee Admission (2001 HHS):	**538**
Illegal Alien Population (2005 FAIR estimate):	**7,000**
Projected Population - 2025 (2001 FAIR):	**1,618,000**
Projected Population - 2050 (2006 FAIR):	**1,810,013**

STATE POPULATION

The Census Bureau estimated that in July 2005 New Hampshire's population had increased by an annual average of about 13,990 residents since 2000 (to **1,309,940** residents). Over that period net international migration (more immigrants arriving than leaving) was adding about 2,095 persons each year. During the same period there was an annual average population gain of about 7,710 residents from net domestic migration (more native-born residents arriving than leaving).

Net immigrant settlement accounted for about 15 percent of the population increase over this period, and that does not include the children born to the immigrants after their arrival in the United States. The current annual average level of immigrant settlement is about 170 percent higher than during the 1990's.

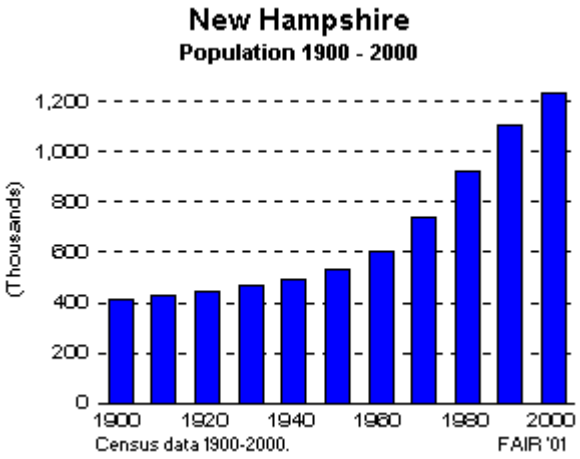




[Note: children born in the United States to immigrants (part of the immigrant stock) are not included as part of the immigration flow.]

The 2000 Census found 1,235,786 persons resident in New Hampshire. This was an increase of 126,534 persons above the 1990 Census. The rate of increase (11.4%) was the 22nd highest in the country.

The 2000 population is about 12,000 more persons than the Census Bureau had expected to find in the state in 2000 when it issued its most recent state population projections in 1996. The significance of this is that the Census Bureau has concluded that much of the shortfall in their population estimates during the 1990s was due to an underestimation of the illegal alien population.



New Hampshire had the 11th greatest rate of population increase in the country between 1960-2000.

Between 1980-1990, the state's overall population increased by 20.5 percent (from 920,610 to 1,109,252).

FOREIGN-BORN POPULATION

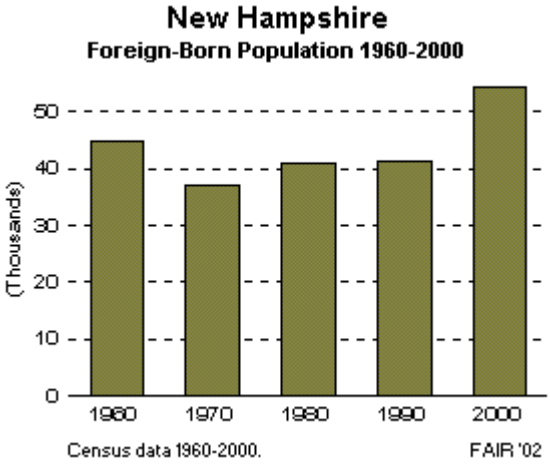
FAIR estimates that the foreign-born population of New Hampshire was about 65,260 residents in July 2005. This meant a foreign-born population share of 5 percent. The amount of change since the 2000 Census indicates an average annual rate of increase in the foreign-born population of about 2,095 people, which is 15 percent of the state's annual average population increase. In addition, the Center for Immigration Studies recently estimated that 23 percent of babies being born in the United States are to foreign-born mothers. This share of the state's current births would be about 1,615 children born to immigrants in 2004-05, and the total share of population increase combining new immigration and births to foreign-born mothers would be about 27 percent of the state's overall population increase.

The Census Bureau estimates that the foreign-born population share in New Hampshire was 5.0 percent in 2003. This implies a foreign-born population of about 64,400 people. The amount of change since the 2000 Census indicates an annual rate of increase in the foreign-born population of about 3,100 people, which is 19.7 percent of the state's annual average population change.

The 2000 Census recorded 54,154 foreign-born residents in the state. That was 4.4 percent of the state's overall population and an increase of 31.5 percent above the 1990 foreign-born population of 41,193 residents. That rate of increase in the immigrant population was much higher than the 10.6 percent increase in the state's native-born population, but it was lower than the national average increase of 57.4 percent in the foreign-born population.

A comparison of the increase in the immigrant population from 1990 with the change in the overall population during the same period shows that immigrant settlement directly accounted for 10.2 percent of the state's overall population increase over that decade. The share of the

population increase due to immigration would be still higher if the children of the immigrants born here after their arrival were included with their immigrant parents in the calculation.



New Hampshire ranked 40th nationally in the rate of foreign-born change between 1960-2000.

The 2000 Census found that 37.3 percent of New Hampshire's foreign-born population had arrived in the state since 1990. This demonstrates the effects of the current mass immigration, although it was a lower share than the national average (43.7%).

An indicator of the change in the immigrant population may be seen in data on the share of the population that speaks a language other than English at home. Between 1990 and 2000 the share of non-English speakers at home in New Hampshire decreased slightly, from 8.7 percent to 7.5 percent. Less than one-third (29.2%) of those who said they spoke a language other than English at home in 2000 also said they spoke English less than very well.

Speakers of Foreign Languages
(at home in New Hampshire in the 2000 Census)

French	39,550
Spanish	18,645
German	4,780
Greek	3,410
Chinese	2,735
Italian	2,650
Portuguese	2,395
Polish	2,095
Arabic	1,460
Vietnamese	1,450

(Source: Census Bureau report: Language Spoken at Home for the Population 5 Years and Over, April 2004)

In the 1990 Census, New Hampshire had about 41,000 immigrants. This represented 3.7 percent of the state's total population, compared to the national average of 7.9 percent. The number of foreign born remained virtually unchanged from the 1980 Census, although

Foreign-Born Change Since 1980: Top Ten Countries 1980-2000

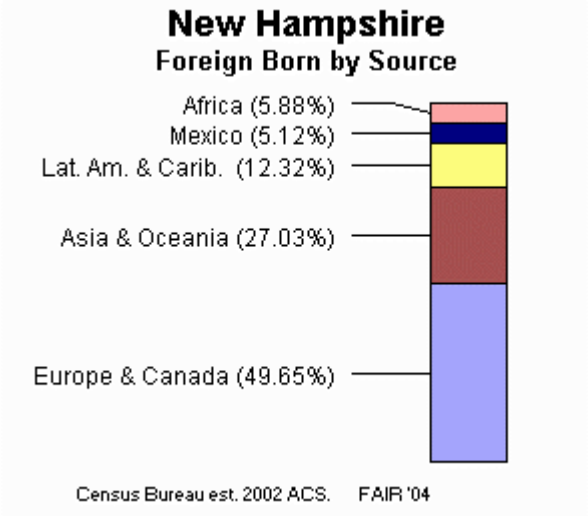
Rank	Country	1980	Country	1990	Country	2000
1	Canada	18,629	Canada	13,823	Canada	12,397
2	U.K.	3,787	U.K.	3,839	U.K.	4,396
3	Germany	2,723	Germany	2,725	China *	2,725
4	Greece	1,732	Greece	1,310	Germany	2,670
5	Poland	945	India	1,274	India	2,530
6	Italy	897	Italy	893	Korea	1,582
7	Ireland	726	Korea	815	Vietnam	1,440
8	Sov.Un.	641	Ireland	761	Mexico	1,419
9	France	509	Poland	754	Greece	1,261
10	Korea	451	Philip.	666	Dom.Rep.	1,227
	All Others	9,921	All Other	14,333	All Others	22,507
	Total	40,961	Total	41,193	Total	54,154

* 2000 Census data for China include Hong Kong and Taiwan.

The ten countries above constituted nearly three-fifths (58.4%) of the foreign-born population in New Hampshire in 2000. Canada alone accounted for more than one-fifth (22.9%) of all of the state's foreign-born population.

The foreign-born population increased by 0.6 percent from 1980-1990 (40,961 to 41,193 residents). Slightly more than one-quarter of New Hampshire's immigrant population in 1990 were newcomers since 1980.

The Census Bureau estimated from its American Community Survey that in 2002 the foreign-born population of New Hampshire was about 56,000 persons. The chart below shows the regions from which those foreign residents came.

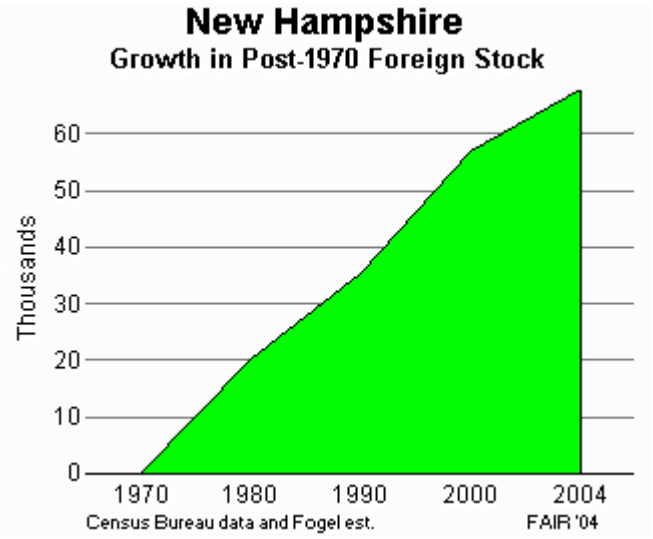


IMMIGRATION AND NATURALIZATION SERVICE DATA (Click here for data on immigrant settlement.)

THE IMMIGRANT STOCK

The Census Bureau estimated that there were about 174,000 people in New Hampshire in 2000 who were "immigrant stock." That is a term that refers to immigrants and their children born here after their arrival. Based on that estimate, and the population of 1,235,786, the immigrant stock share of the state's population was 14.1 percent.

As the graph below shows, the amount and share of New Hampshire's population change due to the increase in the foreign stock is rising rapidly. Over the past 34 years the new immigrants and children born to them have added about 67,900 people to the population. Over this period, the increase in the foreign stock has accounted for 12 percent of the state's population increase.

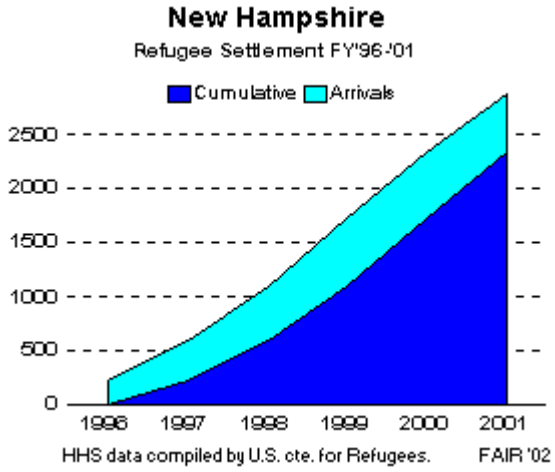


NATURALIZATION

Data from the 2000 Census recorded New Hampshire's naturalized population at 25,761 residents. That was a naturalization rate of 47.6 percent, higher than the national average rate of 40.1 percent. The declining rate of naturalization (see 1990 data below) indicates an increasing immigrant population, including illegal immigrants.

Data from the 1990 Census showed that 55.5 percent of New Hampshire's 41,193 foreign-born residents had become naturalized U.S. citizens. This was much higher than the national average (40.3%).

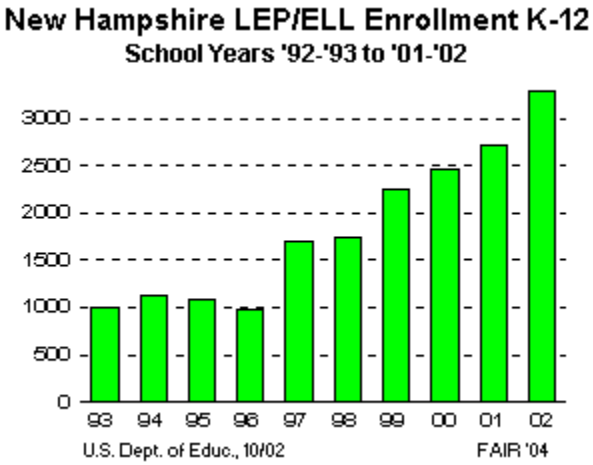
Refugee Settlement
New Hampshire has received 2,870 refugees over the most recent six fiscal years (FY'96-'01) for permanent resettlement (538 in FY'01). This is an average of nearly 480 refugees per year.



Under the Office of Refugee Resettlement's (HHS) assistance funding for FY'02 $432,679 is available for refugee employment training and other services programs in New Hampshire based on a three-year refugee settlement program covering 1,724 refugees (an average of $251 per refugee). This allocation does not include a larger share (55%) of funding programs for communities heavily affected by recent Cuban and Haitian entrants, communities with refugees whose cultural differences make assimilation especially difficult, communities impacted by federal welfare reform changes, educational support to schools with significant refugee students, and discretionary grants.

LIMITED ENGLISH PROFICIENCY STUDENTS

Data are not available nationally on immigrant students (either legally or illegally resident in the United States) who are enrolled in primary and secondary schools (K-12). However, many of these students are enrolled in Limited English Proficiency/English Language Learning (LEP/ELL) instruction programs. Many may be U.S.-born, but the majority of these students may be assumed to be either immigrants or the children of immigrants, with the exception being areas with native Americans who speak a native language other than English.

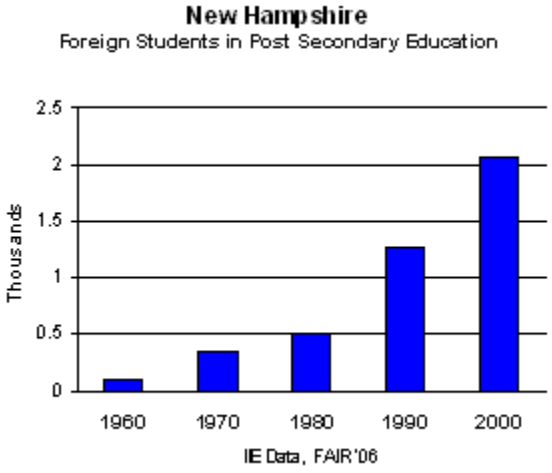


In New Hampshire, overall enrollment in 2002 (211,429) was 6.1 percent above enrollment in 1993. By contrast, LEP enrollment (3,286 - 1.6% of all enrollment) was 227 percent higher than a decade earlier.

Data on enrollment in LEP/ELL programs are collected by the federal government from school systems that receive Title VII funds for these special instruction programs. The data on LEP/ELL enrollment are understated because data from private schools that do not apply for Title VII assistance are sketchy.

FOREIGN STUDENTS

The 2004/05 annual report of the Institute of International Education (IIE) lists the number of foreign students enrolled in post-secondary school in New Hampshire as 2,061. The chart below shows the sharp increase in foreign students attending school in New Hampshire from 1960-2000.



For information on foreign student issues see: Foreign Students in the United States.

ILLEGAL ALIENS

The INS estimate of the illegal alien population released in February 2003 listed New Hampshire as having an illegal alien population of less than 2,500 residents. This compares with the previous INS estimate of 2,000 illegal aliens as of October 1996. That estimate was a one-third increase over the 1,500 illegal alien residents previously estimated for October 1992.

New Hampshire has received partial compensation under the federal State Criminal Alien Assistance Program (SCAAP) that was established in 1994 to compensate the states and local jurisdictions for incarceration of "undocumented," aliens who are serving time for a felony conviction or at least two misdemeanors.

The recent SCAAP amounts that New Hampshire has received were:

FY'99—$552,985
FY'00—$351,286
FY'01—$260,936
FY'02—$366,323
FY'03—$159,718
FY'04—$207,721

The amount of SCAAP awards has been declining in both total distributions and even more as a share of the state's expenses. In FY'99 the state received 38.6% of its costs for 74 prisoner years of detention. By FY'02, the state's reported illegal alien detention increased by 32 percent to 98 prisoner years, while compensation decreased by 34 percent and since has decreased further.

MEDICAL COSTS OF ILLEGAL ALIENS

Under the Emergency Medical Treatment and Labor Act, hospitals with emergency rooms are required to treat and stabilize patients with emergency medical needs regardless whether or not they are in the country legally or whether they are able to pay for the treatment. Congress in 2003 enacted an appropriation of $250 million per year (for 4 years) to help offset some of the costs due to use of this service by illegal aliens. This amount has been allocated among the states based upon estimates of the illegal alien population and data on the apprehension of illegal aliens in each state. This amount compensates only a fraction of the medical outlays. For New Hampshire, the proposed payment in fiscal year 2004 is $47,694.

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Pew Hispanic Center

Fact Sheet

April 26, 2006

Estimates of the Unauthorized Migrant Population for States based on the March 2005 CPS

(In thousands)

U.S. total **11,100 (10,700–11,500)**

California	**2,500–2,750**	Indiana	**55–85**
Texas	**1,400–1,600**	Iowa	**55–85**
Florida	**800–950**	Oklahoma	**50–75**
New York	**550–650**	New Mexico	**50–75**
Arizona	**400–450**	Kansas	**40–70**
Illinois	**375–425**	South Carolina	**35–75**
Georgia	**350–450**	Missouri	**35–65**
New Jersey	**350–425**	Nebraska	**35–55**
North Carolina	**300–400**	Kentucky	**30–60**
		Alabama	**30–50**
Virginia	**250–300**	Mississippi	**30–50**
Maryland	**225–275**	Arkansas	**30–50**
Colorado	**225–275**		
Washington	**200–250**	Louisiana	**25–45**
Massachusetts	**150–250**	Idaho	**25–45**
Nevada	**150–200**	Rhode Island	**20–40**
		Hawaii	**20–35**
Pennsylvania	**125–175**	Delaware	**15–35**
Oregon	**125–175**	District of Columbia	**15–30**
Tennessee	**100–150**	New Hampshire	**10–30**
Michigan	**100–150**		
		Alaska	**<10**
Ohio	**75–150**	Wyoming	**<10**
Wisconsin	**75–115**	South Dakota	**<10**
Minnesota	**75–100**	Maine	**<10**
Utah	**75–100**	Vermont	**<10**
Connecticut	**70–100**	North Dakota	**<10**
		Montana	**<10**
		West Virginia	**<10**

Based on March 2005 Current Population Survey

Pew Hispanic Center

A Pew Research Center Project

1615 L Street, NW, Suite 700 • Washington, DC 20036-5610 • Phone: 202-419-3600 • Fax: 202-419-3608

www.pewhispanic.org

The estimates reported here for the number of unauthorized migrants* living in the 50 states and the District of Columbia are based on a well-established methodology applied to data from the March 2005 Current Population Survey (CPS). The CPS, a monthly survey of about 50,000 households conducted jointly by the U.S. Bureau of Labor Statistics and the Census Bureau, is best known as the source for monthly unemployment statistics. Every March both the sample size and the questionnaire of the CPS are augmented to produce the Annual Social and Economic Supplement, which provides additional data on several additional subjects, including the foreign-born population.

As previously reported, the Center's analysis of the March 2005 CPS shows that there were an estimated 11.1 million unauthorized migrants in the United States a year ago. Based on analysis of other data sources that offer indications of the pace of growth in the foreign-born population, the Center developed an estimate of 11.5 to 12 million for the unauthorized population as of March 2006. A full report on the estimates including a description of the methodology can be found in: Size and Characteristics of the Unauthorized Migrant Population in the U.S.: Estimates Based on the March 2005 Current Population Survey (http://pewhispanic.org/reports/report.php?ReportID=61)

The March CPS supplement in any given year does not provide enough data to provide a precise point estimate of the size of the unauthorized population in all states. Variability in the survey sample precludes precise year-to-year comparisons for some sub-populations. Therefore, the estimates by state are presented here as a range. While based primarily on the March 2005 CPS, the estimates developed out of an analysis of CPS-based estimates for 2000 to 2005 and Census-based estimates for 2000. The analysis included both an examination of trends across the estimates for all six years and averaging of results in two- and three-year increments to reduce the effects of sample variability.

In addition to the reports noted above, the Center has produced two other fact sheets regarding unauthorized migrants based on the analysis of the March 2005 CPS:

The Labor Force Status of Short Term Unauthorized Workers

(http://pewhispanic.org/files/factsheets/16.pdf)

Recently Arrived Migrants and the Congressional Debate on Immigration

(http://pewhispanic.org/files/factsheets/15.pdf)

* The term "unauthorized migrant" is used in reference to these estimates because the statistical methodology involved in deriving the estimates requires the inclusion of some persons who have temporary permission to reside in the U.S. or whose immigration status is unresolved.

April 24, 2006

New Hampshire Department of Education
Division of Program Support - Bureau of Information Services
101 Pleasant Street, Concord, NH 03301-3860
Telephone: (603) 271-2778 Fax: (603) 271-3875

State Totals - Ten Years Public and Private Fall Enrollments
1996-1997 Through 2005-2006

Public District Schools

	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06
Preschool	1,540	1,576	1,585	1,696	1,877	1,830	1,923	2,221	2,360	2,525
Kindergarten	8,552	8,744	8,809	9,032	9,160	9,599	9,757	9,989	10,116	10,360
Readiness	938	874	729	613	454	432	352	293	260	210
Grade 1	17,164	16,403	16,409	15,818	15,624	15,443	15,196	15,071	15,009	14,733
Grade 2	16,507	16,820	16,249	16,206	15,587	15,563	15,319	14,951	14,978	14,940
Grade 3	16,401	16,604	16,858	16,390	16,372	15,776	15,748	15,403	15,019	14,976
Grade 4	16,378	16,421	16,662	16,948	16,541	16,612	15,939	15,810	15,495	15,147
Grade 5	16,121	16,502	16,600	16,910	17,167	16,756	16,769	16,045	15,950	15,627
Grade 6	16,379	16,208	16,822	16,818	17,171	17,422	16,971	16,889	16,200	16,093
Grade 7	15,736	16,532	16,497	16,922	16,893	17,314	17,667	17,166	17,009	16,358
Grade 8	15,518	15,728	16,561	16,508	16,874	17,111	17,421	17,703	17,224	17,035
Grade 9	14,962	15,200	15,388	16,317	16,315	16,513	16,625	17,131	17,302	16,973
Grade 10	13,433	14,009	14,070	14,235	15,047	15,188	15,524	15,659	16,012	16,224
Grade 11	12,103	12,562	13,215	13,372	13,508	14,304	14,419	14,894	14,766	15,203
Grade 12	10,468	10,991	11,451	11,986	12,206	12,541	13,499	13,618	13,893	13,998
Spec Ed Elem	518	547	422	487	524	448	431	348	368	377
Ungraded Elem	82	80	96	1	4	11	1	0	7	0
Spec Ed Sec	94	49	111	56	185	132	65	128	183	135
Ungraded Sec	91	64	28	39	54	58	71	23	55	28
Post Graduate	4	5	8	9	5	19	18	17	17	33
Totals	**192,989**	**195,919**	**198,570**	**200,363**	**201,568**	**203,072**	**203,715**	**203,359**	**202,223**	**200,975**

Public Academies & Joint Maintenance Agreement

	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06
All Grades	3,212	3,303	3,461	3,605	3,731	3,775	3,969	4,058	4,548	4,592

Public Charter

	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06
All Grades	0	0	0	0	0	0	0	0	81	200

Total Public

	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06
All Grades	196,201	199,222	202,031	203,968	205,299	206,847	207,684	207,417	206,852	205,767

Total - Nonpublic Schools

	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06
All Grades	21,057	21,642	22,515	22,995	23,820	24,114	23,828	23,470	22,736	22,237

Total - All Schools

	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06
All Grades	217,258	220,864	224,546	226,963	229,119	230,961	231,512	230,887	229,588	228,004

Revised 4/10/06
See Footnote (4)

NEW HAMPSHIRE DEPARTMENT OF EDUCATION
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STATE AVERAGE COST PER PUPIL AND TOTAL EXPENDITURES 2004-2005

	Elementary	Middle/Jr.High	High	Total
Part A - Expenditures				
Operating Expenses for Public Schools	$883,231,182	$345,881,230	$544,843,599	$1,773,956,011
Tuition (less interdistrict transfers)	17,687,076	12,185,791	80,638,866	110,511,733
Transportation	40,387,495	16,753,758	27,936,971	85,078,224
Elem and Secondary Current Expenses [1]	$941,305,753	$374,820,779	$653,419,436	$1,969,545,968
Capital Items (other than facilities reported below)				24,014,353
Bonds & Notes Interest				48,783,166
Total Recurring Elementary and Secondary Expenditures				$2,042,343,487
Facility Construction & Acquisition				138,598,107
Total Expenditures for Elementary and Secondary Education				$2,180,941,594
Current Expenditures Not Part of Public Elementary & Secondary				
Summer School	$1,333,528	$512,351	$989,447	$2,835,326
Non-public Programs				374,917
Adult Education				4,512,999
Community/Jr. College Ed. Program				116,839
Community Service				1,407,203
Allocation to Charter Schools/Other Agencies				825,456
Total Expenditures for 2004-2005 [2]				$2,191,014,334
Part B - Pupil Memberships				
Average daily membership in attendance [3]	$93,897.1	$40,417.6	$60,656.4	$194,971.1
Part C - Cost Per Pupil				
Operating Expenses for Public Schools	$9,406.37	$8,557.69	$8,982.46	$9,098.56
Tuition (less interdistrict transfers)	188.37	301.50	1,329.44	566.81
Transportation	430.13	414.52	460.58	436.36
Elem and Secondary Current Expenses	$10,024.87	$9,273.71	$10,772.48	$10,101.73
Capital Items (other than facilities reported below)				$123.17
Bonds & Notes Interest				250.21
Total Recurring Expenditures				$10,475.11
Facility Construction & Acquisition				710.86
Total Expenditures for Elementary and Secondary Education				$11,185.97
Current Expenditures Not Part of Public Elementary & Secondary				
Summer School	$14.20	$12.68	$16.31	$14.54
Non-public Programs				1.92
Adult Education				23.15
Community/Jr. College Ed. Program				0.60
Community Service				7.22
Allocation to Charter Schools/Other Agencies				4.23
Total Expenditures for 2004-2005				$11,237.63

Footnotes

1 Inter-district tuition payments have been deducted. Inter-district transportation payments of $223,165 can not be attributed to a grade level and have not been deducted.

2 Does not include Bond Principal repayment of: $88,933,867
Bond Principal repayments are not included because expenditures financed by bonds and notes have already been reported as expenditures in the current or a previous year.

3 High school average daily membership (ADM) does not include ADM of 86.0 for students attending vocational programs out-of-state.

4 State Average Cost per Pupil change since January 19, 2006 is due to changes in the ADM to Derry Cooperative, Exeter Regional Cooperative, Hopkinton, Litchfield and Pittsfield school districts.

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Cost-Shifting in New Hampshire Hospitals, 2004

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February 2006

About this paper

We thank the New Hampshire Hospital Association (NHHA) for sharing with us the audited financial statements and standard financial spreadsheets that they collect from the hospitals in the state. The analysis and opinions expressed in this paper, however, are those of the Center alone.

This paper is one of a series published by the NH Center for Public Policy Studies on the broad topic of health-care finance and insuring the New Hampshire workforce. The Concord-based Endowment for Health has sponsored this work.

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Cost-Shifting in New Hampshire Hospitals, 2004

Contents

Executive Summary

Payments made by health insurers to New Hampshire's 26 community acute care hospitals in 2004 were 138 percent of the cost of hospital services. In 2001, insurers had paid 123 percent of cost. Increased cost-shifting and higher hospital operating margins were the cause of the increase.

In 2004, New Hampshire's 26 acute care hospitals *charged* $4.39 billion for their patient services. This was 206 percent of the actual *cost* of those services. With the exception of a small number of uninsured patients, all payers paid considerably less than the charged amounts. The charge amounts were so high in comparison that they could be described as "list price" fiction.

Medicare paid, on average, 84 percent of cost and caused a net loss for hospitals of $137 million. Medicaid paid 69 percent of cost and caused a net loss for hospitals of $48 million. The hospitals also provided uncompensated care (consisting of both charity care and bad debt) at a loss of $116 million. Altogether, compensation for services from these sources fell short of actual cost by $300 million. This is the amount that the hospitals had to shift onto other payers in order to break even.

Commercial insurers paid an average of 138 percent of cost for the services that the hospitals provided to their insured members. This resulted in a net gain of $357 million for the hospitals. The hospitals were also paid considerably more than cost by some self-pay patients and others. These generated a net gain of an additional $75 million. Thus, the hospitals not only successfully covered their losses due to below cost payments but ended up with a net gain of $131 million, a margin of 5.9 percent. These are aggregate averages. However, the specifics varied considerably among the 26 hospitals.

Furthermore, when insurers made payments that included the cost-shift amount and margin for the hospitals, they had to pass that amount on to their policy holders in premiums. They also had to add their own administrative costs and profit margin. On average in 2004 the portion of a health insurance premium that paid for actual hospital care for an insured person was 162 percent of the cost of that hospital care.

Preliminary evidence suggests that the higher Medicare payments made to small hospitals that obtain a "Critical Access" designation not only increases the financial viability of those hospitals but also results in lower payments from insurers relative to cost because the need for cost-shifting is reduced.

Commonly, uncompensated care is thought to be provided almost exclusively to the uninsured, but that is not actually the case. In 2004, of the $116 million cost of uncompensated care, $87 million was for persons who were uninsured while $29 million was for persons who had health insurance but were unable to pay their deductibles or co-payments. As high deductible insurance policies become more commonplace, uncompensated care to insured persons may grow. Hospitals should begin recording and presenting to the public the value of uncompensated care that they are actually providing to persons who do have health insurance but cannot meet their deductibles or co-pays.

Statewide Totals

In 2004, New Hampshire's 26 acute care hospitals provided patient services (both inpatient and outpatient) for which they charged $4.39 billion.[1] However, the true operating cost[2] of their patient services was only $2.13 billion.[3] Hospital charges – the amount billed for services – were, on average, 206 percent of patient services expenses. (Equivalent ways to state this same fact are "the charge/cost ratio[4] was 2.06" and "charges were marked up 106 percent above cost.")

This large difference between charges and cost is explained by the fact that hospitals generally do not anticipate actually being paid their billed charges. Except for some persons who are expected to pay full charges out of pocket, the charge numbers are essentially "list price" fiction. Medicare and Medicaid pay for services based on legally established pay scales, typically at rates far below charges. Health insurers negotiate to pay some discount below charge amounts. As our charts will show, the care for 99 percent of all patients is paid for at rates well below "charges."

It is important to understand the meaning of three basic measures related to hospital finances and not get them confused.

Charges (Gross Patient Service Revenue): *The "list price" for a hospital's services. Because only one percent of payers actually pay charges, it is simply a base to which actual payment can be compared. It is the only financial measure available in some situations.*

Payments (True Net Patient Service Revenue): *The amount of patient service revenue actually received based on fixed fees of government programs, contractual discounts with insurers, and debt written off.*

Cost: *The true expenses of operating the hospital and providing patient services, including wages, equipment, medical supplies, heat, and light, etc.*

Charges *in 2004 were $4,390,899,246.* ***Payments*** *totaled $2,263,211,174.* ***Cost*** *was $2,132,269,242.*

True net patient service revenue was $2.26 billion[5] and other operating revenue[6] was $70 million. Total operating expenses were $2.13 billion. When compared to their costs, this left the hospitals with a net patient service operating income of $132 million.[7] The net operating margin of all 26 hospitals combined was 5.9 percent.[8]

On average, this is a robust financial result. However, it hides both the way in which this amount was generated and the fact that not all hospitals shared in the rosy results equally. The details raise many questions and point out future dangers. Elucidating them is the purpose of this paper.

[1] The 2004 fiscal year is not the same for each hospital. Aggregate figures in this report are derived by simple summing of the numbers for all hospitals, even though they do not cover exactly the same calendar months.
[2] Aggregate cost includes the corporate taxes paid by the two for-profit hospitals, Parkland and Portsmouth.
[3] This is derived by subtracting bad debt and non-patient service expenses from total operating expenses. See Appendix B for details of the methodology.
[4] The methodology used for arriving at the charge/cost ratio is described in Appendix B.
[5] "True net patient service revenue" is derived by subtracting bad debt from net patient service revenue. See Appendix B.
[6] "Other operating revenue" includes revenue from parking lots, gift shops, cafeterias, and other functions that are not direct patient care.
[7] They also had an additional $49 million of non-operating income, mostly from return on investments.
[8] When including the taxes paid by the two for-profit hospitals, the net margin was 5.3 percent.

Revenue By Source

Most hospital care is billed to and then paid for by commercial health insurance, by the federal Medicare program for seniors, by the state Medicaid program for low-income and disabled individuals, and directly by patients who received care. The total amount billed in 2004 was $4,390,899,246. Figure 1 displays the amount and percentage of the gross patient service revenue, what was billed to each major source. Medicare was billed only slightly less than commercial insurers in 2004.

Figure 1

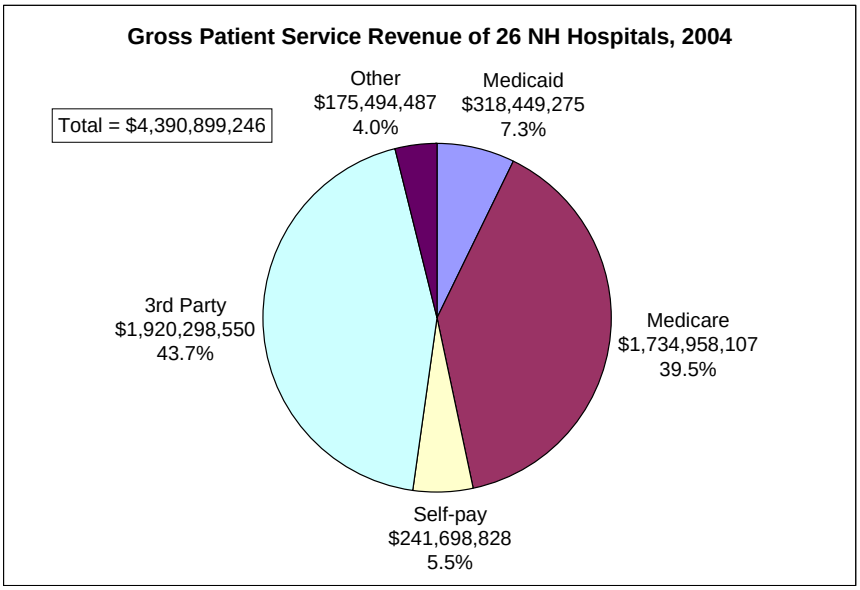
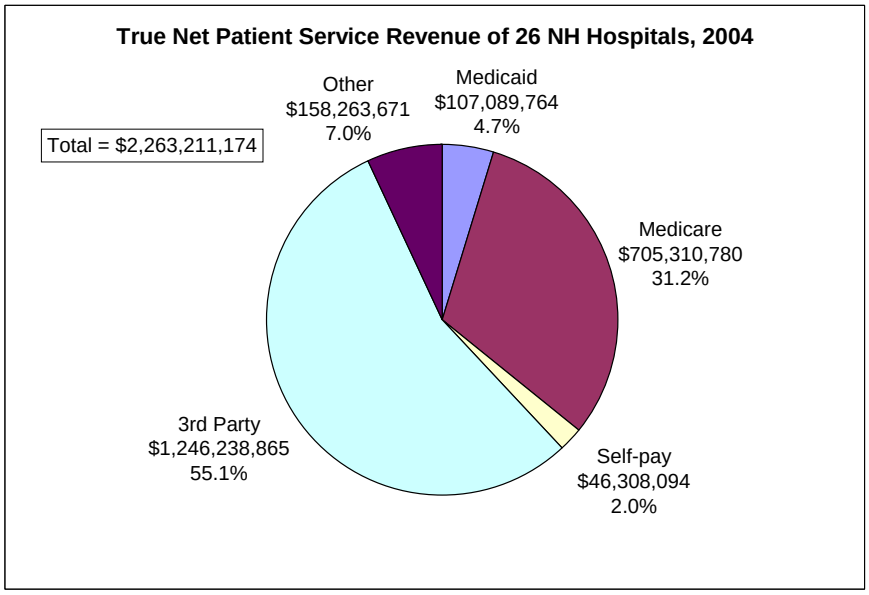


Figure 2



Because of the discounts provided to insurers, the fixed payments of the Medicare and Medicaid programs, charity care provided to individuals, and bad debt[9] that had to be written off, true net patient service revenue was considerably less, $2,263,211,174. The amount and sources of this net patient service revenue are shown in Figure 2.

As shown by these two figures, while charges to Medicare were 39.5 percent of total charges, Medicare payments constituted only 31.2 percent of the revenue hospitals actually received.

Cost-Shifting in 2004

As shown in the figures above, most hospital care is paid for by commercial health insurance, by the federal Medicare program for seniors, the state Medicaid program for low-income and disabled individuals, and directly by patients who have received care. Hospitals also provide charity care and incur bad debt for which they receive no payment. A hospital may be paid very different amounts for the same service by different payers.

A hospital's "patient mix" refers to the relative proportion of its patients whose medical care is paid for by different payer types. Some are Medicare patients, some are self-pay, some have their services paid for by third-party insurers, and some are paid by Medicaid. Different hospitals have different patient mixes. Indeed, patient mix differs considerably by type of the service even within a given hospital.

When payment received for services from any payer is inadequate to cover costs, a hospital must find the financial support for those services from some other source, or the hospital will soon become financially impaired. A common term for this is "cost-shifting." One definition of cost-shifting is, "the allocation of unpaid costs of care delivered to one patient population through above-cost revenue collected from other patient populations."[10] Other terms that are used to describe the same facts are "price shifting," "margin shifting," "price discrimination," and "reimbursement shifting."

In November 2004 the Center published "A Framework for Thinking About Cost-Shifting in Health Care." That report, available on our website, describes in general how to read and understand "hydraulics diagrams," our graphic means to explain cost-shifting. For readers unfamiliar with these diagrams, we suggest that you read that earlier report.

Figure 3 is the hydraulics diagram that exhibits the aggregate of revenues and cost-shifting in New Hampshire's 26 acute care hospitals in 2004.

The horizontal axis of this diagram is divided into 100 sections, each representing one percent of gross charges. It shows that 44 percent of the gross charges were billed to insurance companies

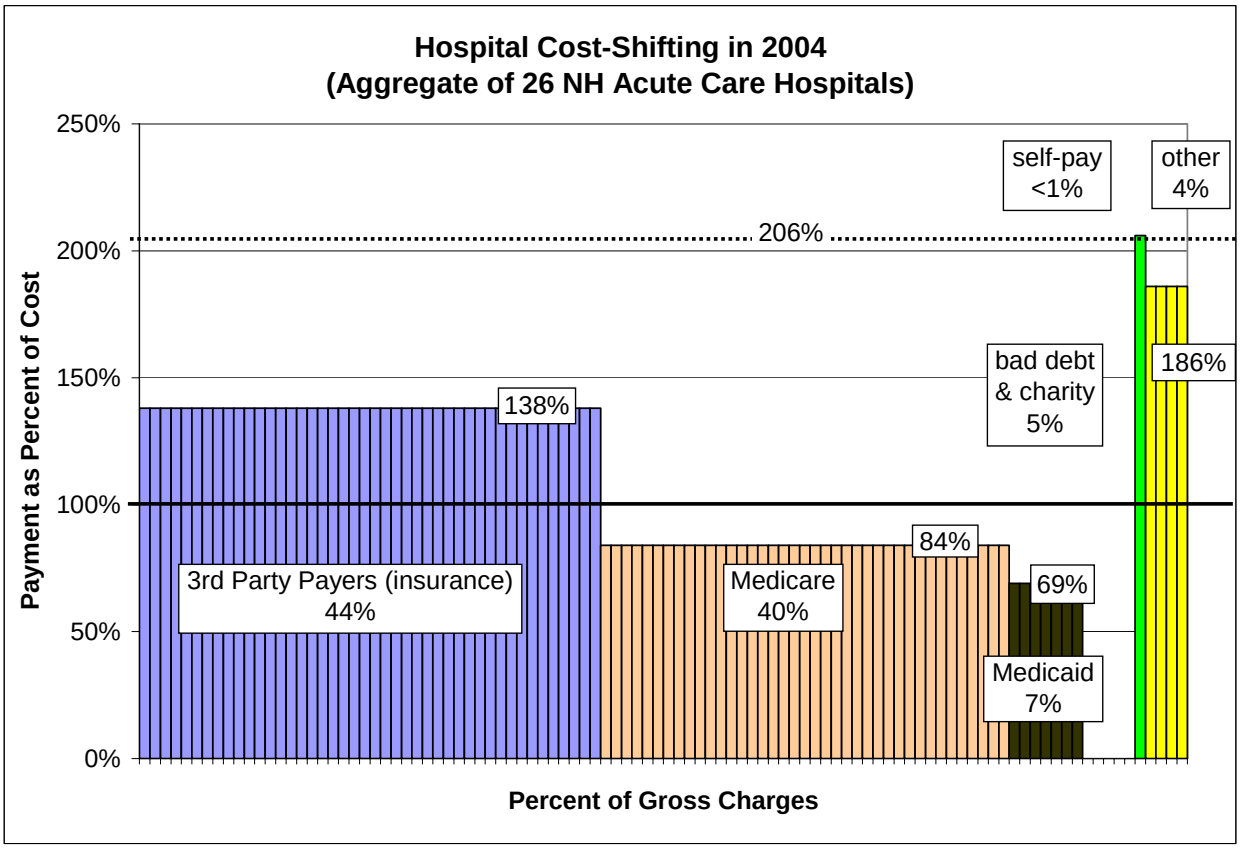
[9] Based on a survey of the hospitals conducted by the NH Hospital Association during the drafting of this report, 74 percent of bad debt in 2004 was attributed to self-pay patients while 26 percent was attributed to insured patients. This was used to derive the true net patient service revenue for each source.

[10] "Cost Shifting: An Integral Aspect of U.S. Health Care Finance," Al Dobson, The Lewin Group, November 13, 2002, at an invitational meeting "When Public Payment Declines Does Cost-Shifting Occur? Hospital and Physician Responses," sponsored by The Robert Wood Johnson Foundation and conducted by AcademyHealth in Washington D.C., November 13, 2002.

on behalf of insured individuals. Another 40 percent of charges were billed to Medicare and 7 percent were billed to the state Medicaid program. Five percent of charges were never paid; they were written off, either as free charity care or as bad debt. About one percent of charges were fully paid by uninsured persons. Four percent were billed to "other."[11]

The vertical axis of Figure 3 displays percentage of cost. A thick black horizontal line marks 100 percent of cost. A payer whose payments exactly equaled costs would be represented by vertical bars that rise exactly to this 100 percent level. A dotted horizontal line marks 206 percent of cost, the average charge amount. The vertical bar representing a payer that actually pays full charges would rise to this level, as the one percent self-pay bar does.

Figure 3



How high the vertical bars rise indicates what percent of cost that payer type actually paid. On average in 2004, insurers paid 138 percent of cost. That is considerably below the amount of charges. The difference between charges at 206 percent of cost and payment at 139 percent of cost represents the average "discount" below charges enjoyed by health insurers.

[11] The "other" category is larger than it should be. A number of hospitals did not differentiate between self-pay and 3rd-party pay in the financial data they submitted to NHHA and submitted the total as "other." Because we cannot separate revenue from these sources if the hospitals do not do so, our "other" category reflects their representation. We suspect that more than half of this category is actually for charges billed to insurance companies, but not so identified by the hospitals.

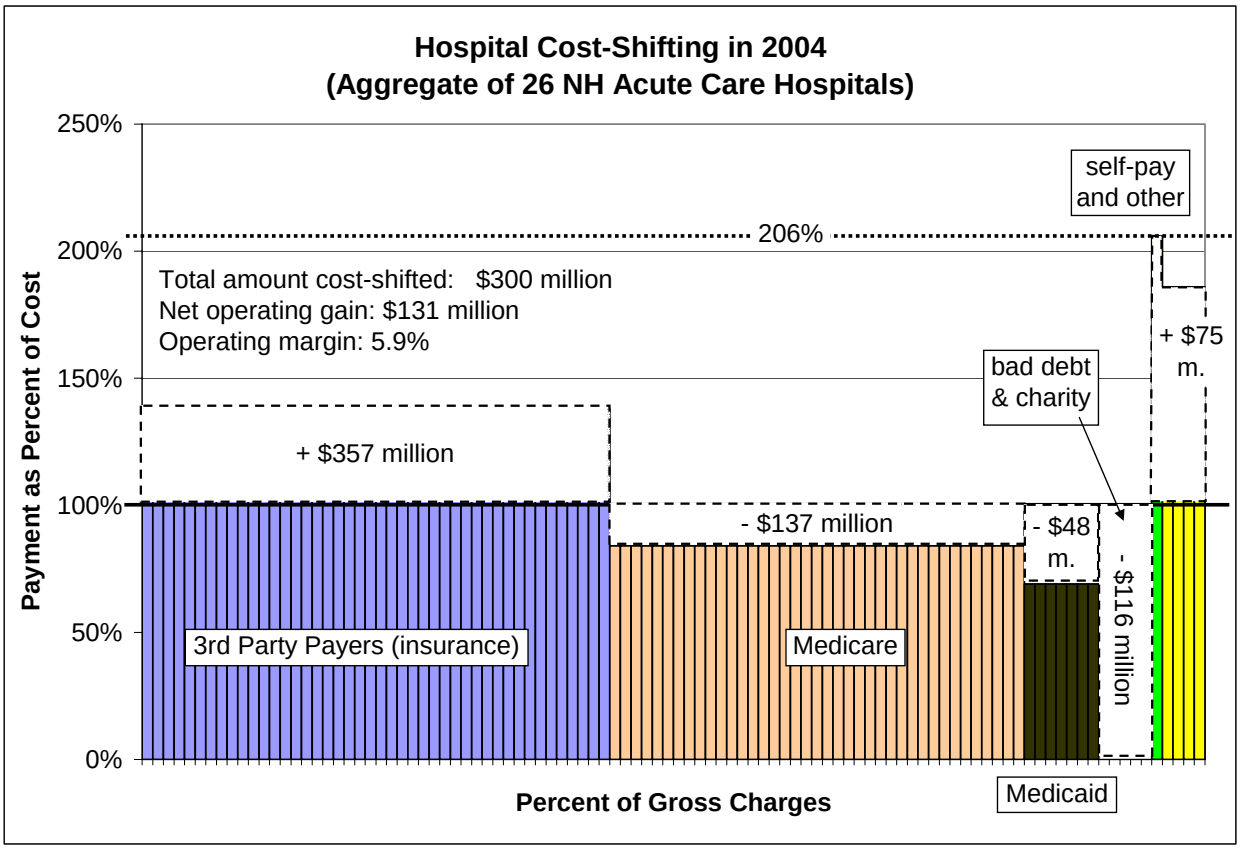
Medicare paid only 84 percent of cost. Medicaid paid even less on average, only 69 percent of cost.

Hospitals obtained $705 million in net revenue from Medicare but $1.289 billion from health insurers on charges that differed by less than $200 million. Hospitals provided care to persons for which they were not compensated.[12] This amounted to $238 million in charges. However, noting that charges are more than double cost, the true cost of this uncompensated care was $116 million.

"Other" payers paid 186 percent of cost.

It is possible to use the data from which Figure 1 is created to calculate the dollar value of the difference between cost and amount paid by each type of payer. This is shown in Figure 4.

Figure 4



In Figure 4, we have been able to quantify and display the cost-shifting in hospitals in 2004.

[12] Uncompensated care consists of "charity care" (care that is provided for free and is typically applied for in advance) and "bad debt" (care for which the hospital expected to be paid but the debtor never made the anticipated payments). These are treated differently under the rules of financial accounting, but for the purposes of this analysis are combined.

Medicare payments were $137 million short of paying for the cost of services to Medicare patients. Medicaid payments were $48 million short of paying for cost. And, as noted above, uncompensated care was $116 million short. From payments received from these three payer types, the hospitals were $300 million short of paying for their costs. To make up the difference the hospitals had to receive more than cost from other payers for patient services.

Payments on behalf of insured persons, mostly from their insurance companies, were $357 million higher than cost. Payments from self-insured persons who paid for their entire hospital care and payments from "Other" payers were $75 million above cost.

The hospitals were able to cost-shift the $300 million they were short, enough to break even. They were also able to obtain $131 million above breakeven, enough to result in an overall operating margin of 5.9 percent.

Comparison to 2001

Our analysis of the 2001 finances of the same 26 hospitals showed that the 3rd party insurers had paid an average of 123 percent of cost that year. In 2004, the 3rd party insurers had paid an average of 138 percent of cost. Much of this increase over the three years is attributed to an increased need to cost shift. Some, however, is due to the fact that the hospitals' average operating margin increased from 4.2 percent in 2001 to 5.9 percent in 2004.

Hospital Bills Paid by Insurance

In 2004, when the average hospital billed an insurance company for $10,000 for services to an insured person, that $10,000 was the *charge* for those services. As noted above, on average, this was 206 percent of the actual *cost* of services. The cost of the services to the hospital was actually $4,854 ($10,000/2.06). However, the insurer paid, on average, 138 percent of cost or $6,699. Some of the $1,845 excess was used by the hospital to offset the below-cost payments for Medicare, Medicaid, and uncompensated care, while the remainder was used to generate a net operating margin for the hospital.

When the payment of $6,699 was received by the hospital, it covered the $4,854 cost for services to the insured person, $1,284 that was cost-shifted to cover services to others, and $561 that was set aside as operating margin for future use. At least this is what happened, on average, in 2004. Figure 5 displays this situation.

It is possible to describe the portion of the payment that is in excess of the actual cost of services to the insured person as a "surtax" or "surcharge." The surtax for cost-shifting was 26.5 percent and the additional surcharge for net margin was 11.5 percent in 2004.[13]

Displaying and describing in this manner how hospitals use the payments they receive from insurers illustrates one important reason why it is possible for some free-standing private health

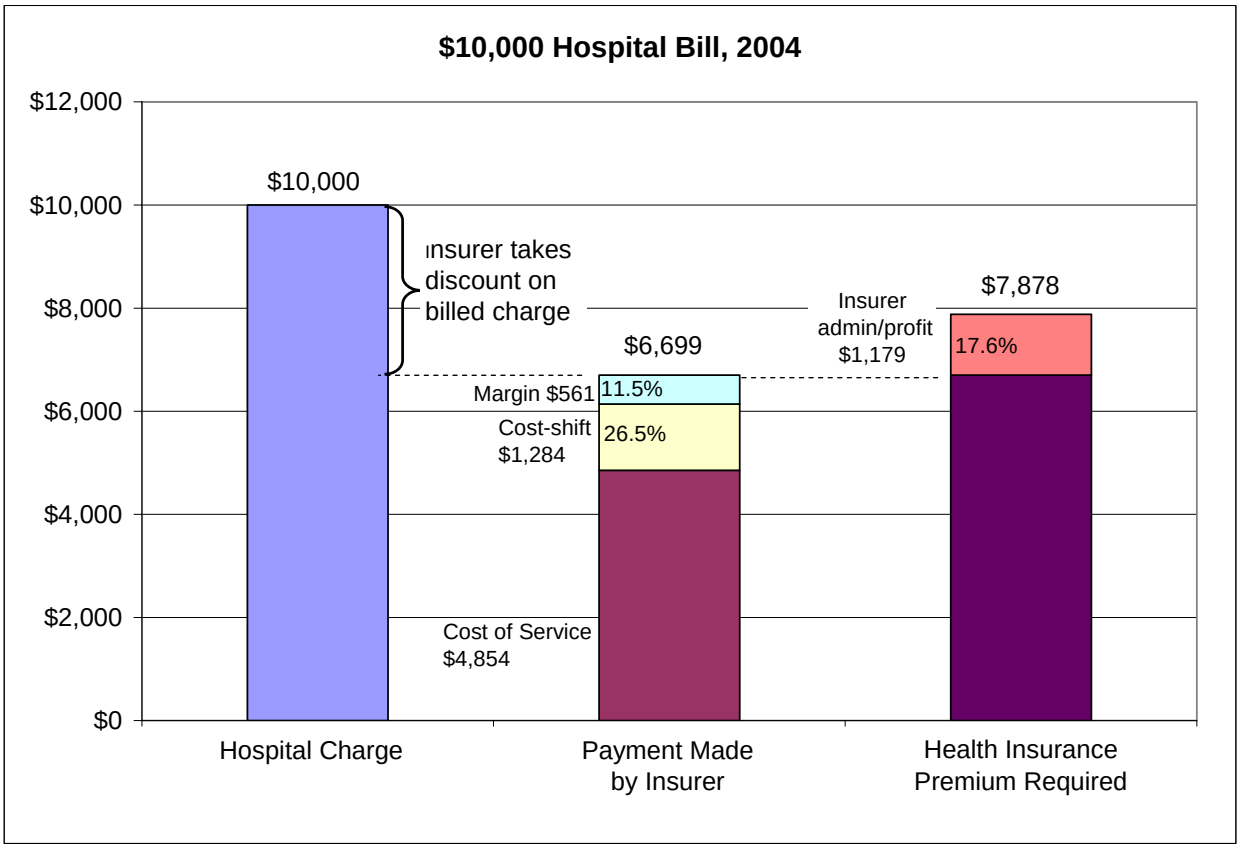
[13] Cost-shifting required $300 million and operating margin $131 million in aggregate. Thus, of the excess, 300/(300+131), or 69.6 percent was required for cost shifting while 131/(300+131), or 30.4 percent was required to generate margin. 69.6 percent of the 38 percent surcharge is 26.5 percent for cost-shifting while the remaining 11.5 percent is for operating margin.

providers to offer certain kinds of equivalent services at lower cost. To the extent these providers do not have an internal 26.5 percent surtax to provide uncompensated care to other persons, they will be able to offer identical services at a lower price even if the actual costs for the service actually delivered to the insured person are the same.

Table 1

Insurance Premium to Pay for Hospital Service, 2004		
Hospital Charge	$10,000	
Actual Cost of Service	$4,854	
Cost-shift surcharge (26.5%)	$1,284	
For operating margin (11.5%)	$561	
Claim to be paid	$6,699	
Claim to pay		$6,699
Insurer admin/profit (17.6%)		$1,179
Premium required		$7,878
Premium as % of cost of service		162%

Figure 5



Health insurers, in turn, must obtain the money they use to pay claims from the premiums they charge to employers and individuals. On average, in 2004, health insurance companies used 85 percent of premiums to pay claims and 15 percent for claims processing, administration, and their own profit.[14] On average, the premium that an insurer had to obtain to pay a $6,699 claim was 117.6 percent of the payment or $7,878.

Therefore, the health insurance premium was 162 percent of the actual cost of delivering the hospital service to the insured individual. This is shown in Table 1 and Figure 5.

Variation Among the Hospitals

The numbers provided in the previous section are totals and averages over all 26 acute care hospitals. However, individual hospitals' operations vary considerably from average. Appendix A contains a cost-shift hydraulics chart for each hospital individually.

New Hampshire's hospitals vary considerably in size, organizational structure, and sophistication of accounting systems. This affects the ability to compare hospitals directly or to draw conclusions about their differences. For example, some large hospitals have affiliated physician practices that are subsidiaries or a separate part of an umbrella holding organization while some small ones have physician practices as a department of the hospital itself. While the NH Hospital Association seeks financial data on the hospital only, some cannot break out the finances of the hospital from the other health care services they provide. We are confident that these differences do not affect the aggregate numbers for all 26 hospitals in any important way. However, we urge readers to use some care in making comparisons between any two hospitals. It is our hope that the differences in financial accounting that may now exist will be eliminated and hospital-to-hospital comparisons will be able to be made on an "apples-to-apples" basis in the future.

On average, charges were 206 percent of cost. Among the hospitals, the lowest was 149 percent while the highest was 278 percent. Table 2 displays the 2004 charge/cost ratio for each hospital in the state, ranked from lowest to highest.

[14] "Basic Facts on Health Insurers in NH, 2001-2004", Douglas E. Hall, New Hampshire Center for Public Policy Studies, October 2005.

Table 2

Below Average of 206%		Above Average of 206%	
Hospital	Charge as % of True Patient Service Expense	Hospital	Charge as % of True Patient Service Expense
Alice Peck Day	149%	Exeter	211%
New London	151%	Cheshire	211%
Cottage	159%	Lakes Region	214%
Franklin Regional	161%	Concord	216%
Littleton	167%	So. NH Regional	217%
Valley Regional	169%	Elliot	217%
Weeks Memorial	171%	Wentworth-Douglass	228%
Monadnock	176%	Parkland Medical (post-tax)	233%
Speare Memorial	179%	St. Joseph	236%
Mary Hitchcock	183%	Catholic Med Ctr	241%
Upper Conn Valley	188%	Portsmouth Regional (post-tax)	243%
Memorial	189%	Parkland Medical (pre-tax)	250%
Androscoggin	192%	Portsmouth Regional (pre-tax)	278%
Huggins	204%		
Frisbie Memorial	204%		

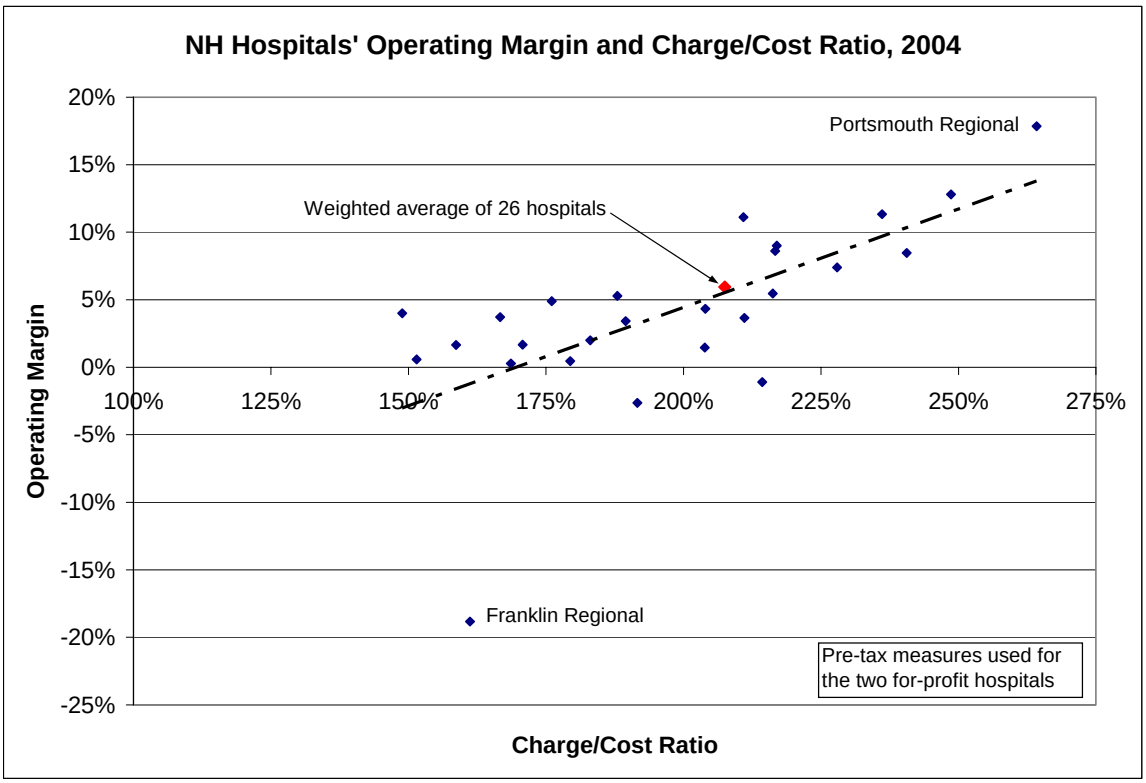
Similarly, the average operating margin (pre-tax) was 5.9 percent. The lowest operating margin was a loss of 18.8 percent while the highest operating margin was a gain of 17.8 percent.

Table 3

Below Average of 5.9%		Above Average of 5.9%	
Hospital	Margin as % of Revenue	Hospital	Margin as % of Revenue
Franklin Regional	-18.8%	Wentworth-Douglass	7.4%
Androscoggin	-2.6%	Parkland Medical (post -tax)	7.4%
Lakes Region	-1.1%	Catholic Med Ctr	8.5%
Valley Regional	0.3%	So. NH Regional	8.6%
Speare Memorial	0.5%	Elliot	9.0%
New London	0.6%	Portsmouth Regional (post-tax)	10.8%
Huggins	1.5%	Exeter	11.1%
Cottage	1.7%	St. Joseph	11.3%
Weeks Memorial	1.7%	Parkland Medical (pre-tax)	12.8%
Mary Hitchcock	2.0%	Portsmouth Regional (pre-tax)	17.8%
Memorial	3.4%		
Cheshire	3.7%		
Littleton	3.7%		
Alice Peck Day	4.0%		
Frisbie Memorial	4.3%		
Monadnock	4.9%		
Upper Conn Valley	5.3%		
Concord	5.5%		

Figure 6 displays one dot for each of the 26 hospitals. This scatter plot shows the charge/cost ratio (pre-tax) and the operating margin (pre-tax) for each hospital. As the trend line shows, those hospitals with charges at a greater advance over cost tended to have higher net operating margins.

Figure 6



The Case of Critical Access Hospitals

As of January 2006, thirteen of the state's 26 hospitals have been designated "Critical Access" hospitals. This designation, which requires the hospitals to agree to various restrictions and requirements, results in Medicare paying for the actual cost of services provided to Medicare enrollees instead of paying based on the standard Medicare rate scale. This stems the necessity to cost-shift Medicare losses onto other payers.

The impact of Critical Access designation can be seen in an example. Cottage Hospital in Woodsville was designated as Critical Access on June 1, 2001.[15] Figures 7 and 8 are hydraulics diagrams for that hospital in 2001 and 2004. In 2004, as a critical access hospital, Medicare reimbursement met cost, whereas Medicare payments were only 76 percent of cost in 2001.

Cottage Hospital was operating with a net operating loss of 5.9 percent in 2001 but had a small net positive operating margin of 1.7 percent in 2004. This difference was primarily caused by the additional Medicare revenue. Medicaid, however, fell from paying 73 percent of cost to paying only 63 percent of cost. The additional revenue from Medicare covered the increased Medicaid

[15] This was a few months before the end of its 2001 fiscal year.

loss, provided the hospital with a small positive balance and actually allowed third party payments to fall a small amount in comparison to cost. Insurers paid 134 percent of cost to Cottage Hospital in 2001 but only 129 percent of cost in 2004.

Figure 7

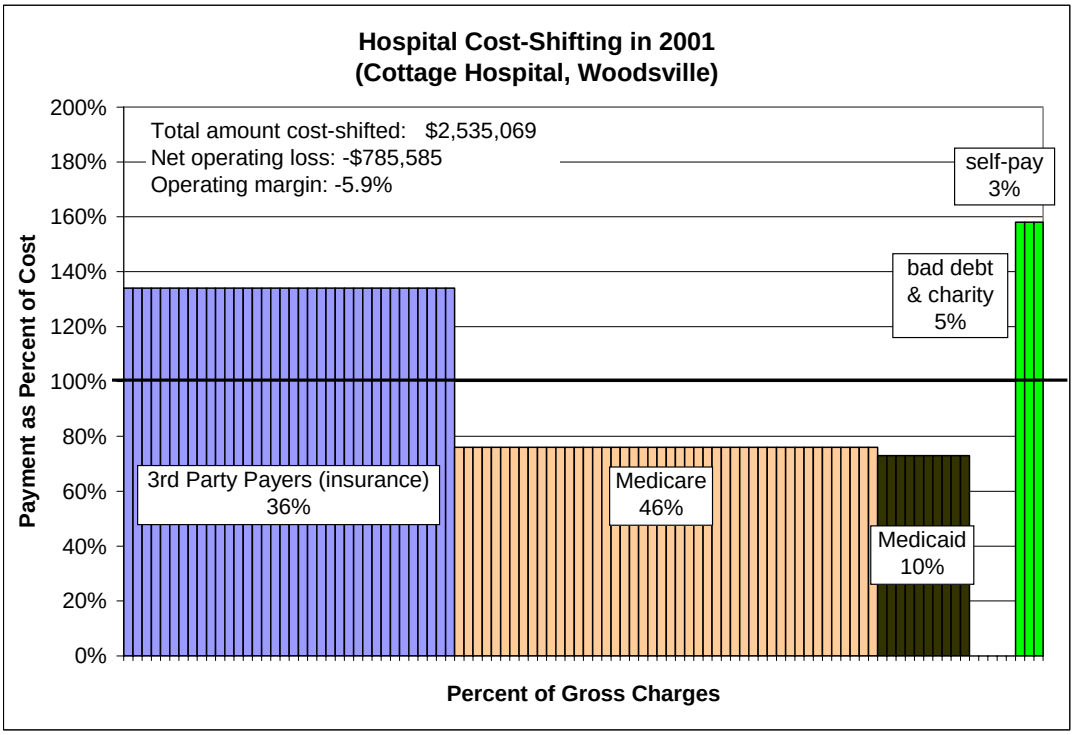
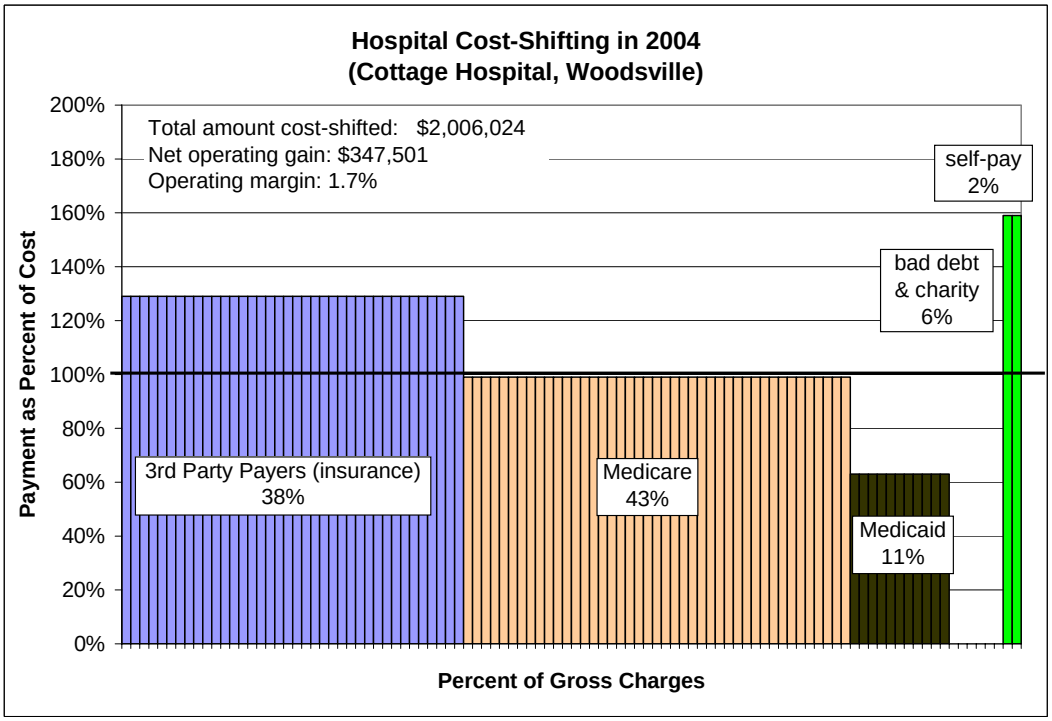


Figure 8



The difference between the two charts indicates that hospitals operating at a loss will use any additional Medicare revenue, first, to stem the loss and obtain a positive operating margin and only then to reduce the surcharge they have had to obtain from other payers. This should not be unexpected. Cost-shifting operates in the presence of a primary need to obtain organizational fiscal stability and a reasonable operating margin. For a non-profit hospital with an already high operating margin, one should expect to see a more direct and significant reduction in the amount surcharged should it receive additional revenue. For a hospital that is operating at a deficit or very close to doing so, the first use of any additional revenue will be to generate a reasonable operating margin.

Table 4 lists all the hospitals that are currently designated as Critical Access in the order in which they have been designated. The financial impact of the designation on these hospitals will be seen only after they complete an entire fiscal year under that designation. It is anticipated that the results will be similar to that displayed above for Cottage Hospital.

Table 4

New Hampshire Critical Access Hospitals		
Date Designated	Hospital	Town
4/1/2001	Upper Connecticut Valley Hospital	Colebrook
6/1/2001	Cottage Hospital	Woodsville
8/1/2001	Weeks Medical Center	Lancaster
9/1/2001	Littleton Regional Hospital	Littleton
4/1/2003	New London Hospital Assn Inc	New London
8/1/2003	Alice Peck Day Memorial Hospital	Lebanon
7/1/2004	Franklin Regional Hospital	Franklin
10/1/2004	Valley Regional Hospital	Claremont
12/27/2004	Monadnock Community Hospital	Peterborough
1/1/2005	Androscoggin Valley Hospital	Berlin
1/1/2005	Memorial Hospital	North Conway
4/1/2005	Huggins Hospital	Wolfeboro
5/5/2005	Speare Memorial Hospital	Plymouth

Medicaid Payments

In 2004, the hospitals provided services to Medicaid patients for which the charges were $318 million. The actual cost of these services was $155 million. The state Medicaid program, however, paid only $107 million toward those costs. This resulted in the need for the hospitals to cost-shift $48 million onto others.

If Medicaid had paid cost, the additional payments would have been made up of $24 million of federal matching funds and $24 million of state funds. Lacking the state funds to increase payment rates and make such payments, the full $48 million was shifted, primarily onto health insurers and, therefore, onto the health care premiums paid by employers and individuals.

Based on their financial reports for 2001, the hospitals provided services to Medicaid patients that cost $99 million and the state paid $67 million. This resulted in the need for the hospitals to cost-shift $32 million that year.

Between 2001 and 2004, therefore, Medicaid payments to the hospitals increased by $40 million. This was not sufficient to pay for the increased cost of $56 million for the services they provided to Medicaid patients in 2004. Therefore, in 2004, in comparison to 2001, an additional $16 million was cost-shifted from Medicaid onto insurers and patients who paid their hospital bills directly.

Uncompensated Care

In 2004, hospital charges to self-pay individuals (those without any form of private or public insurance) totaled $242 million. Uncompensated care (valued at charges) totaled $238 million ($94 million in charity care and $144 million in bad debt). How can the amount of uncompensated care be so close to the total amount billed to uninsured patients? Doesn't that mean the uninsured patients never paid much at all?

The answer is that uncompensated care is not all attributable to self-pay patients. Some uncompensated care is actually generated by patients who are insured but cannot pay their deductible or co-pay amounts. Some is for patients who have health insurance but their insurance will not pay for the particular service that was provided (mental health services, for example).

At our request, while this report was in its first draft, the NH Hospital Association sought more information from the hospitals on the uncompensated care of 2004. Seventeen of the 26 hospitals broke out the charges they had written off as charity care and bad debt for patients who were uninsured and for patients who did, in fact, have health insurance. Table 5 presents the results.

Table 5

	Charity Care	Bad Debt	Total Uncompensated Care
Uninsured Self-Pay Patients	81%	71%	74%
Insured Patients	19%	29%	26%
All Patients	100%	100%	100%

Applying these percentages to the total uncompensated care reported by all 26 hospitals in 2004, we calculated the value of that attributable to insured persons and to uninsured persons. The results are shown in Table 6. Of the $238 million in uncompensated care, we estimate that $178 million was provided to patients without health insurance while $60 million was provided to patients who had health insurance but could not or did not pay for their deductibles or co-payments.

Table 6

	Charity Care (Charges)	Bad Debt (Charges)	Total Uncompensated Care (Charges)
Uninsured Self-Pay Patients	$76,174,989	$102,115,211	$178,290,200
Insured Patients	$17,868,207	$41,709,030	$59,577,237
All Patients	$94,043,196	$143,824,241	$237,867,437

Recognizing that charges were 206 percent of the actual cost of care, the value of the uncompensated care valued at cost can be easily calculated and is shown in Table 7.

Table 7

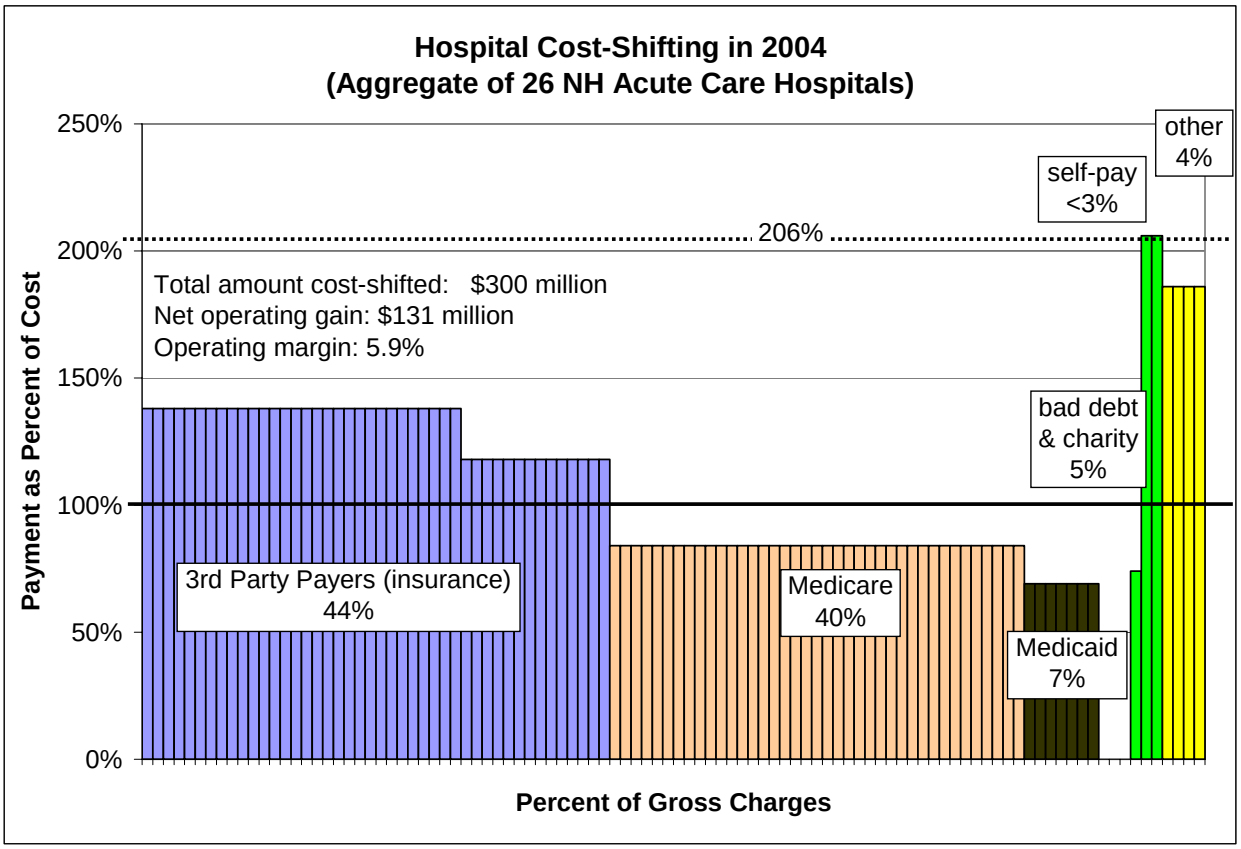
	Charity Care (Cost)	Bad Debt (Cost)	Total Uncompensated Care (Cost)
Uninsured Self-Pay Patients	$36,978,150	$49,570,491	$86,548,641
Insured Patients	$8,673,887	$20,247,102	$28,920,989
All Patients	$45,652,037	$69,817,593	$115,469,630

The hydraulics diagrams of Figures 3 and 4 were developed with the assumption that all uncompensated care was for self-pay patients. In fact, that misallocates $60 million of charges. In Figure 9 we have taken the actual situation into consideration.

The “notch” removed from the 3rd Party Payers part of this figure represents the $60 million in uncompensated care provided to insured patients. The amount shown as being paid by self-pay patients has been increased by an equal $60 million by the addition of one full and one partial bar in that category on the right side of the figure. This more accurately represents the actual situation.

We recommend that hospital financial reporting in future years clearly distinguish between uncompensated care to insured and uninsured persons. This distinction will grow in importance in the next few years. As high deductible insurance plans become more widespread as it appears certain they will, it is likely that the amount of bad debt and charity care attributable to those who are insured will increase. The finance officers of hospitals and policy-makers alike will need to distinguish between these two types. For example, cost estimates for proposals to pay for care to the uninsured will be too high if the assumption is made that all uncompensated care is to those who are uninsured.

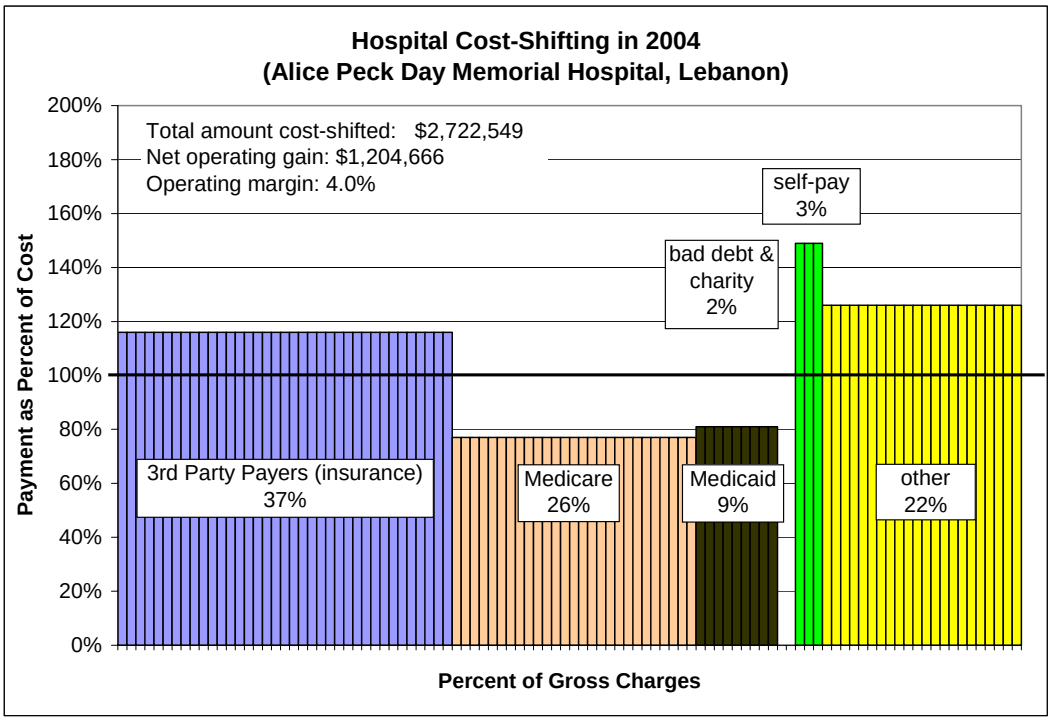
Figure 9



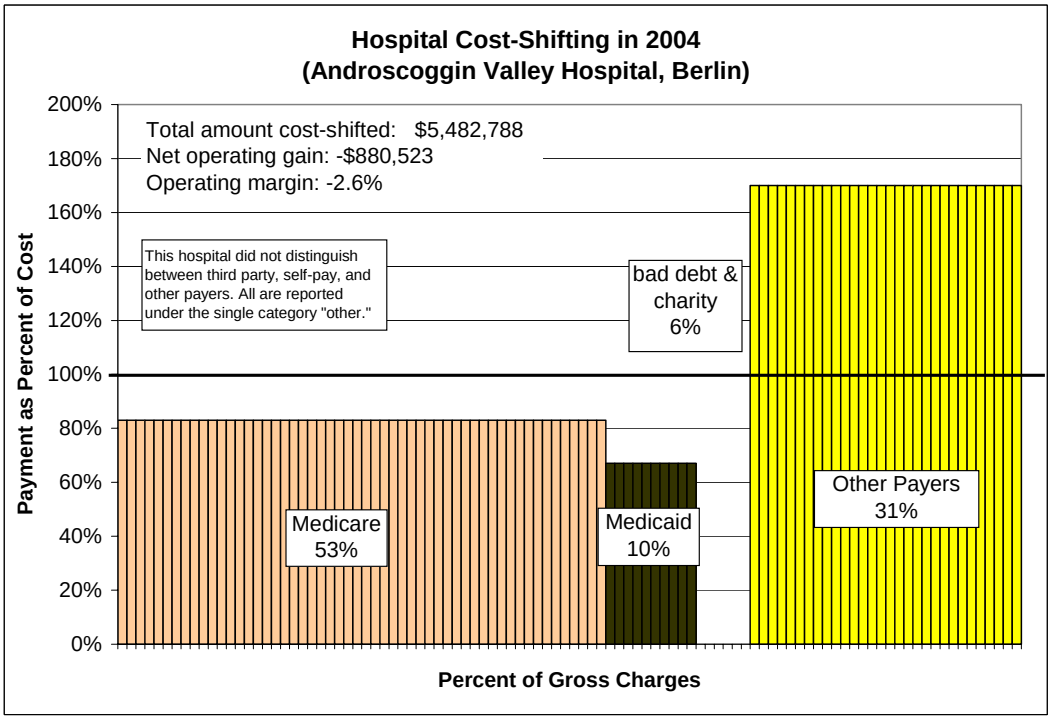
Current financial statements and audits of hospitals mask this distinction between the two sources of uncompensated care. The true nature and size of uncompensated care among insured patients should be broken out and displayed in those reports in the future.

Appendix A: 2004 Hydraulics Charts for 26 Hospitals

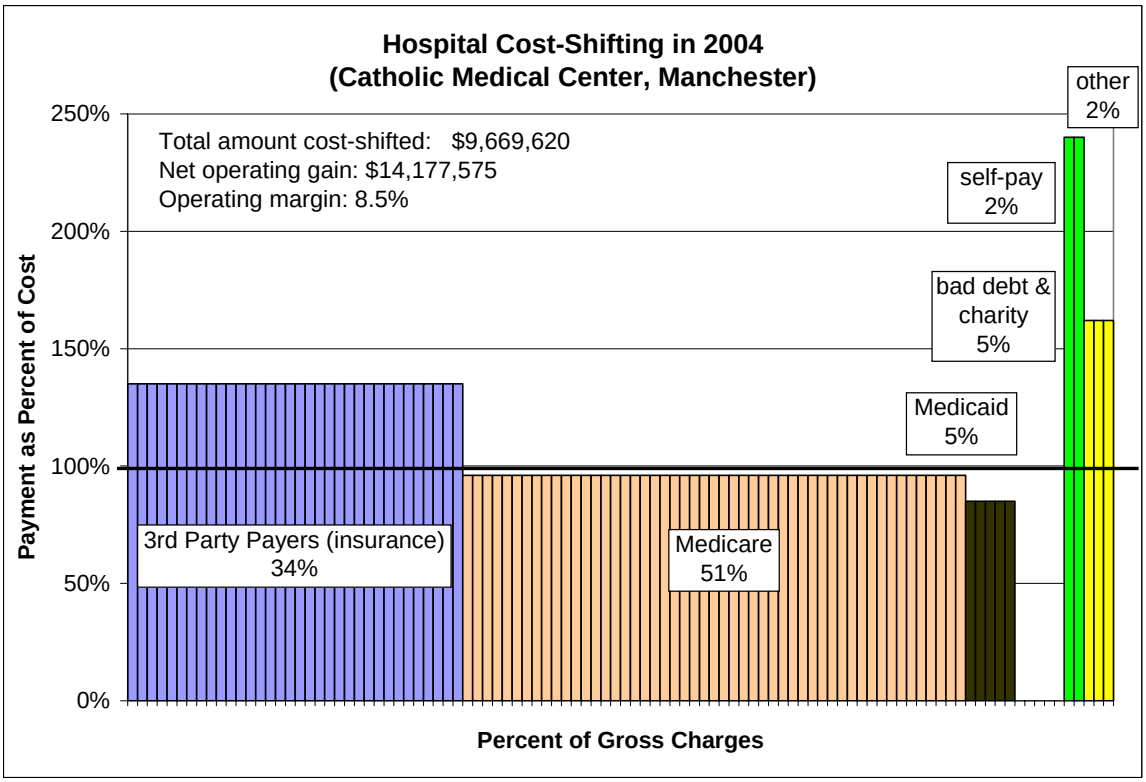
Alice Peck Day Memorial Hospital, Lebanon



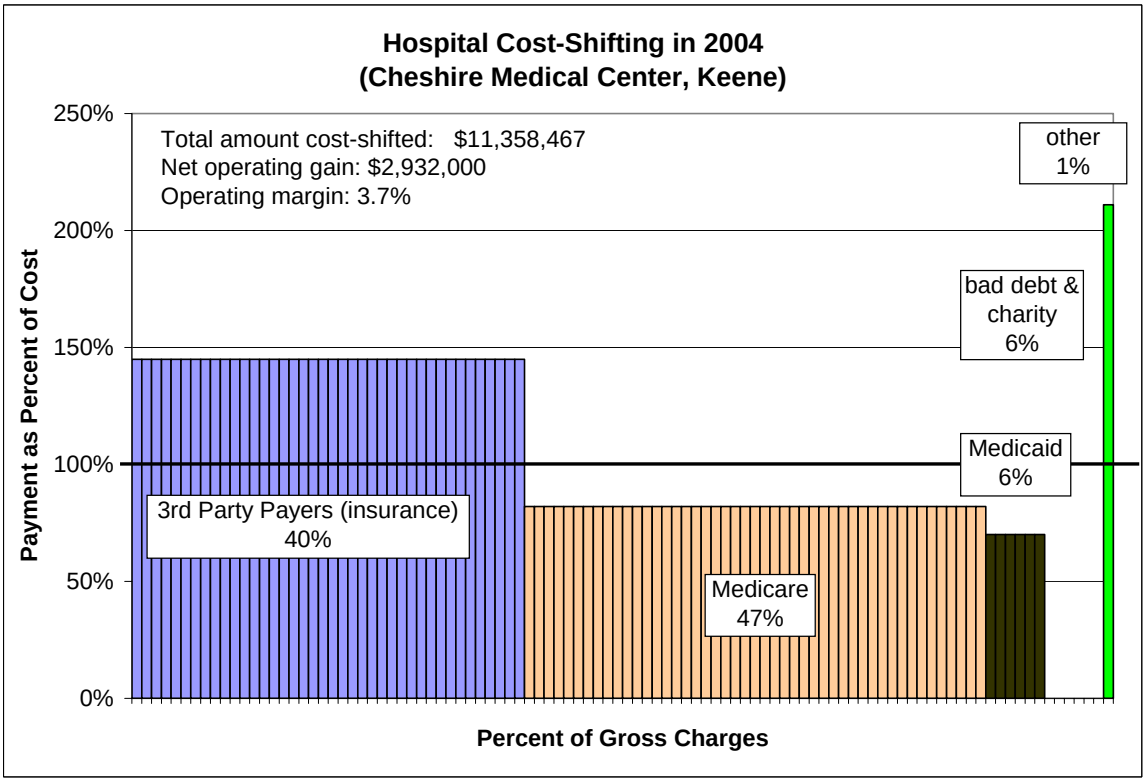
Androscoggin Valley Hospital, Berlin



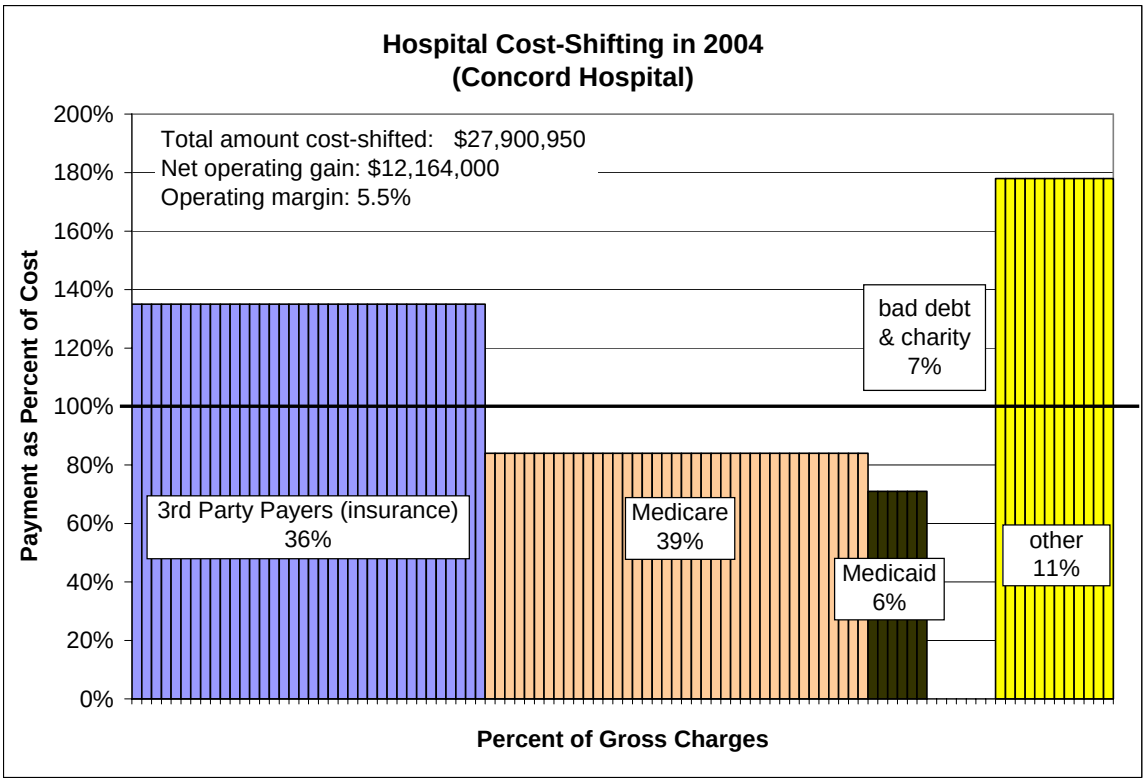
Catholic Medical Center, Manchester



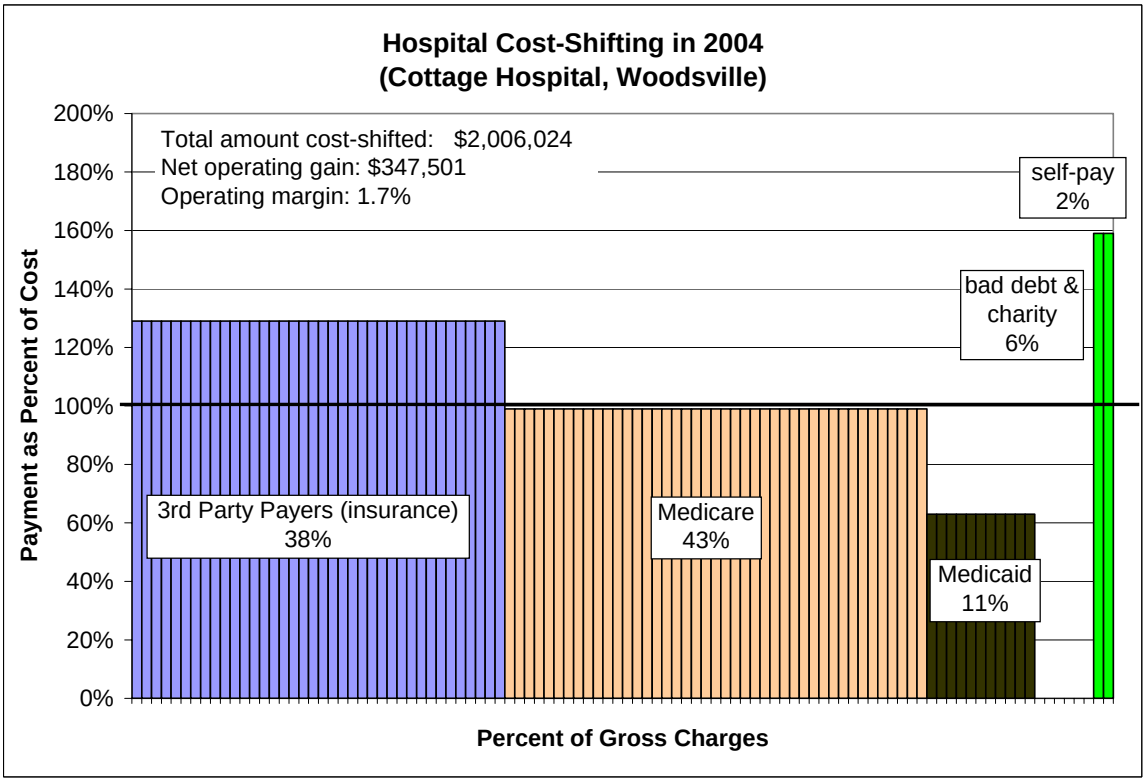
Cheshire Medical Center, Keene



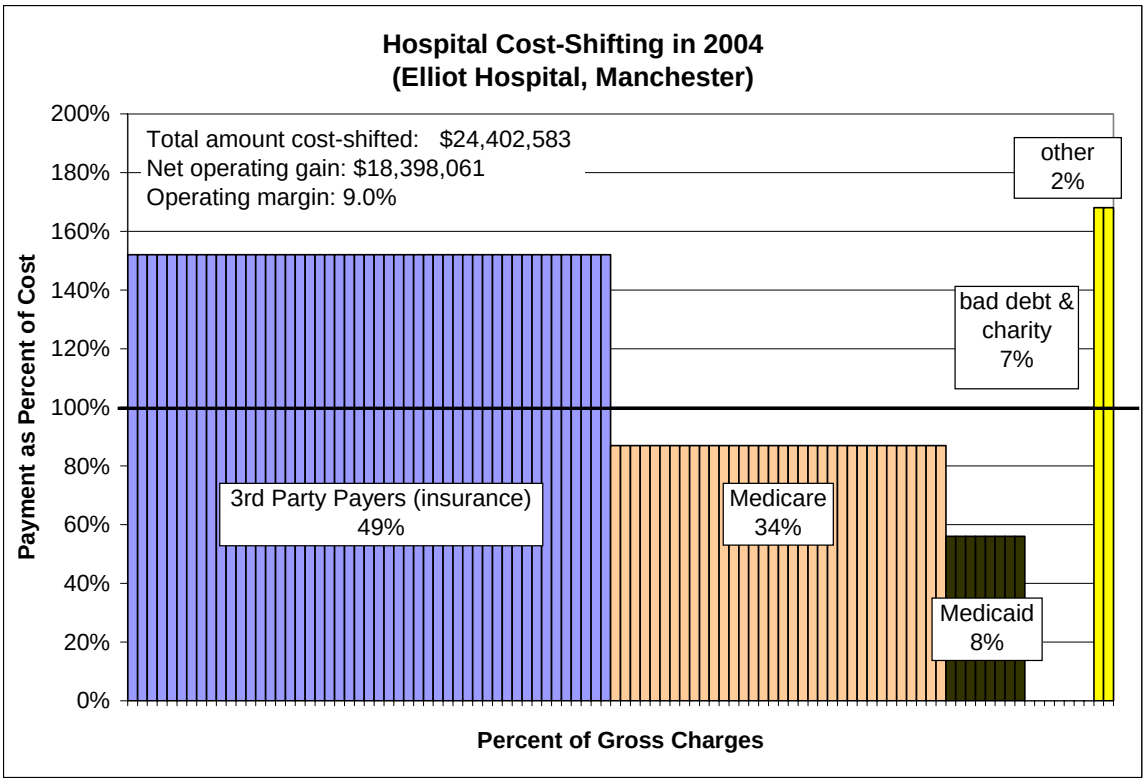
Concord Hospital



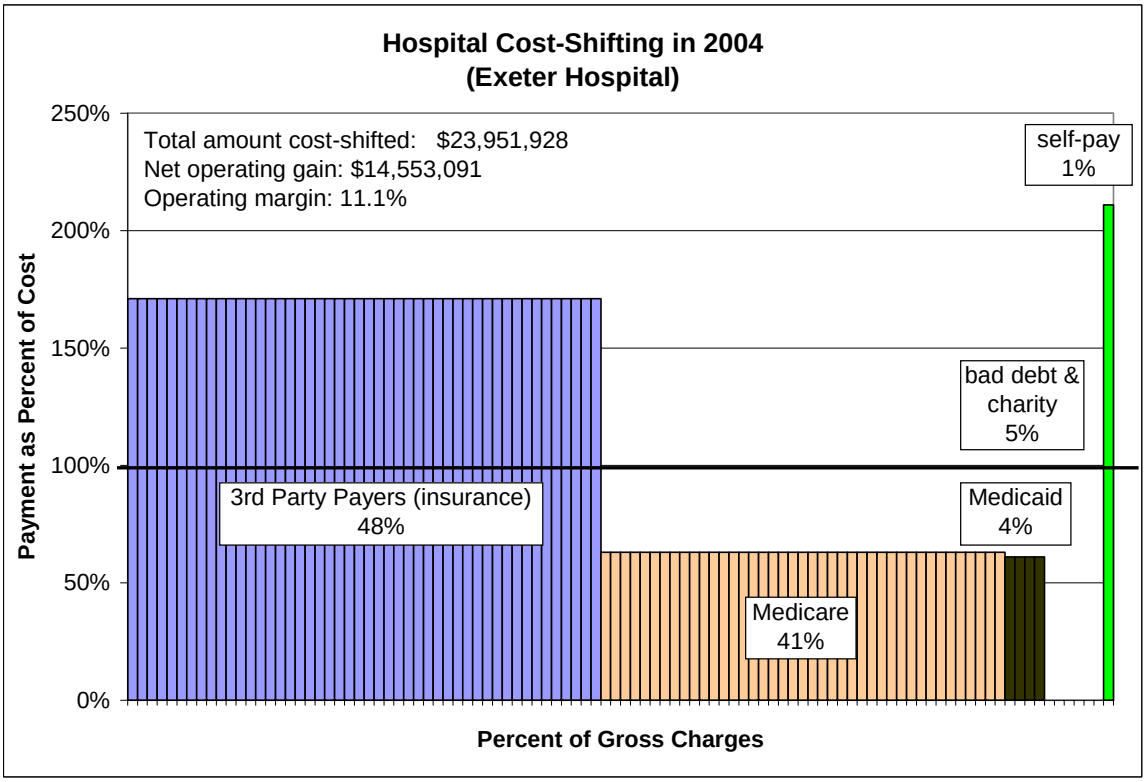
Cottage Hospital, Woodsville



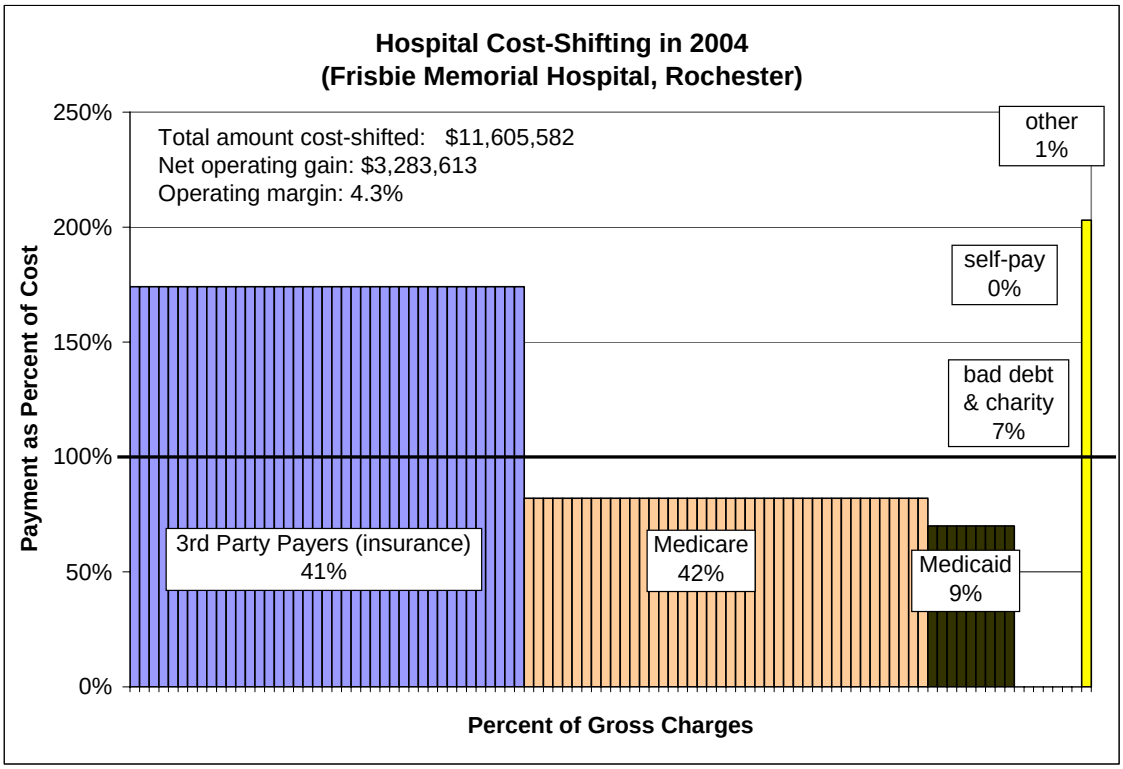
Elliot Hospital, Manchester



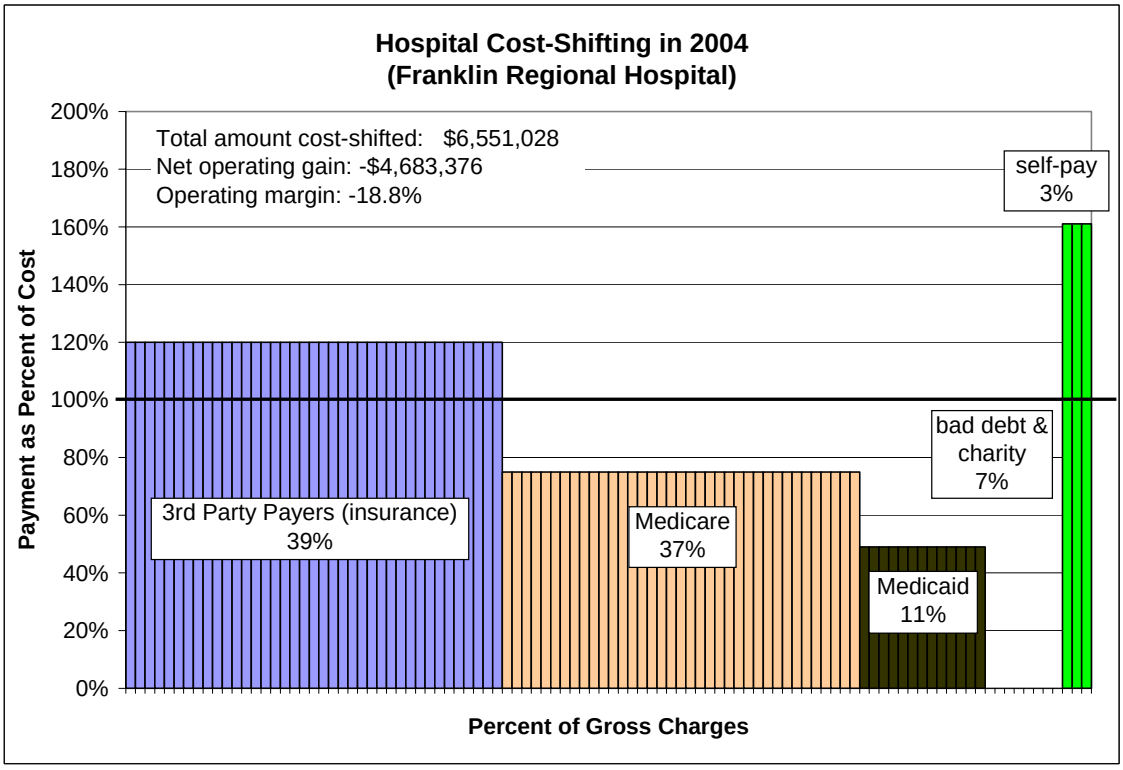
Exeter Hospital, Exeter



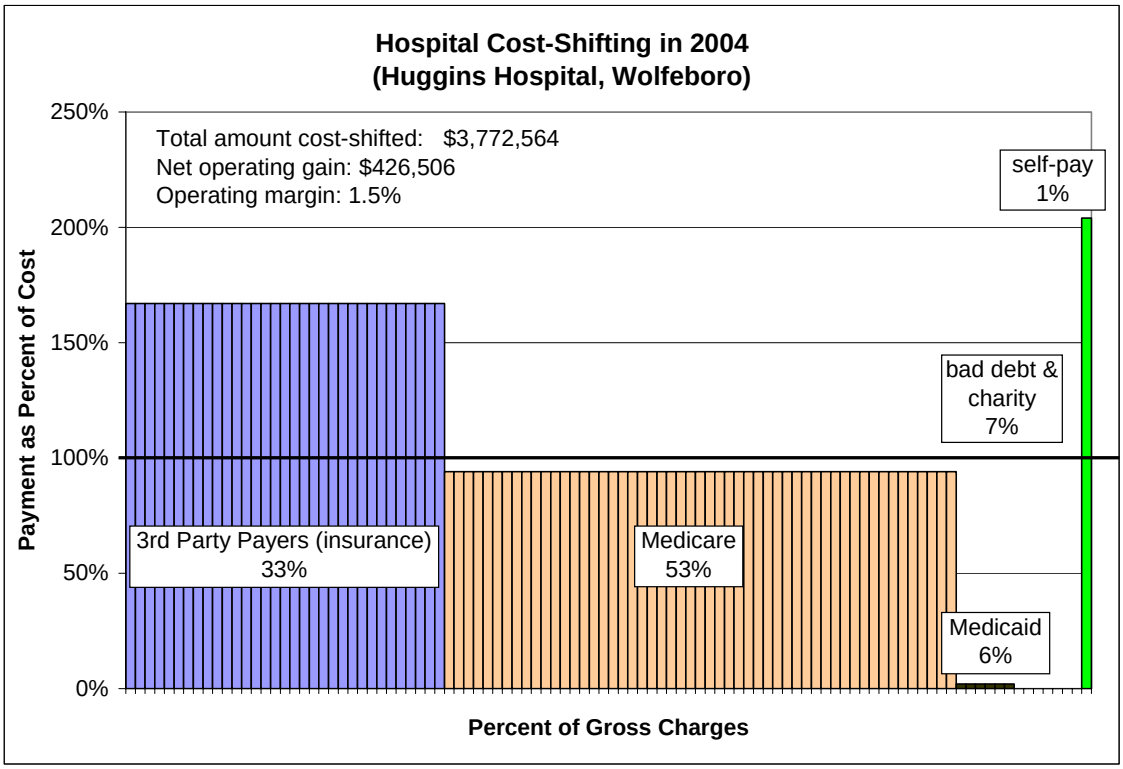
Frisbie Memorial Hospital, Rochester



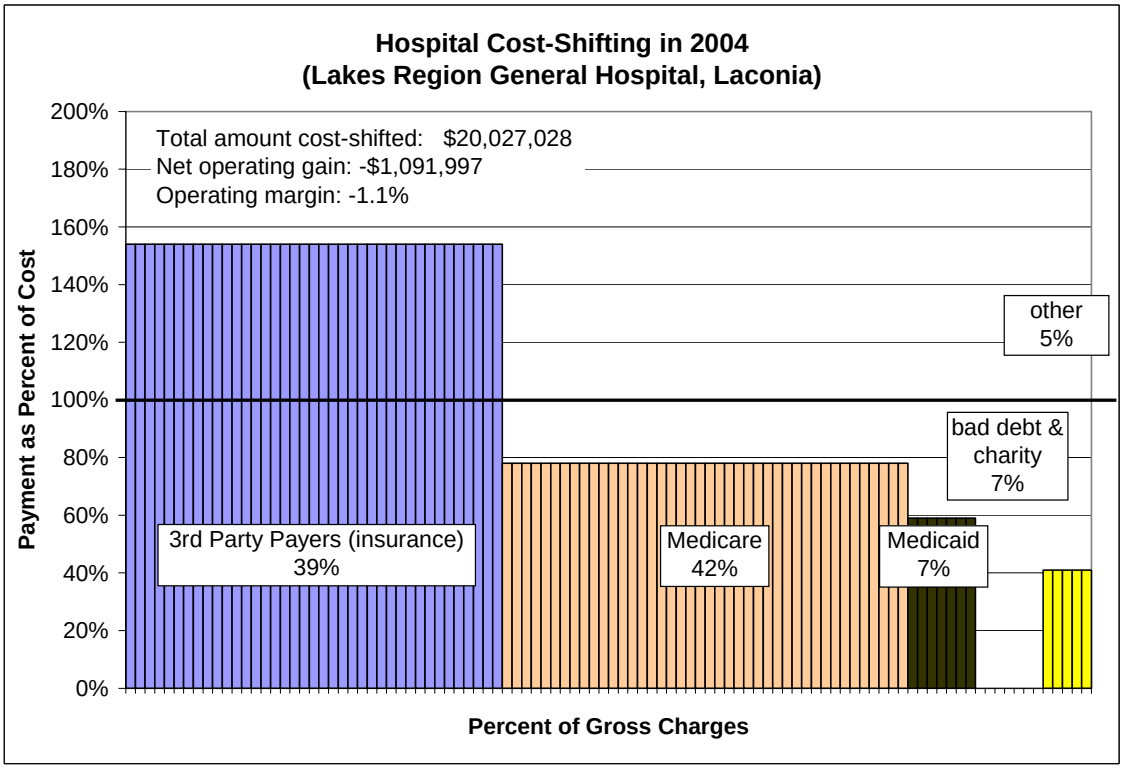
Franklin Regional Hospital



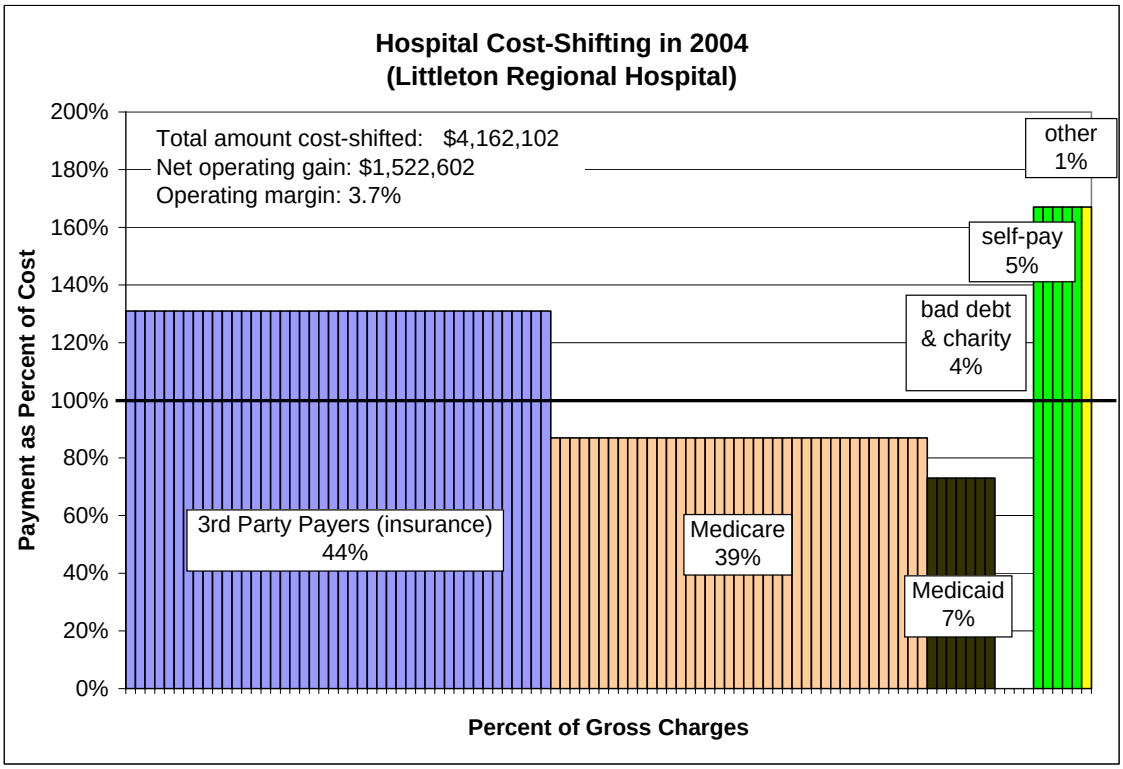
Huggins Hospital, Wolfeboro



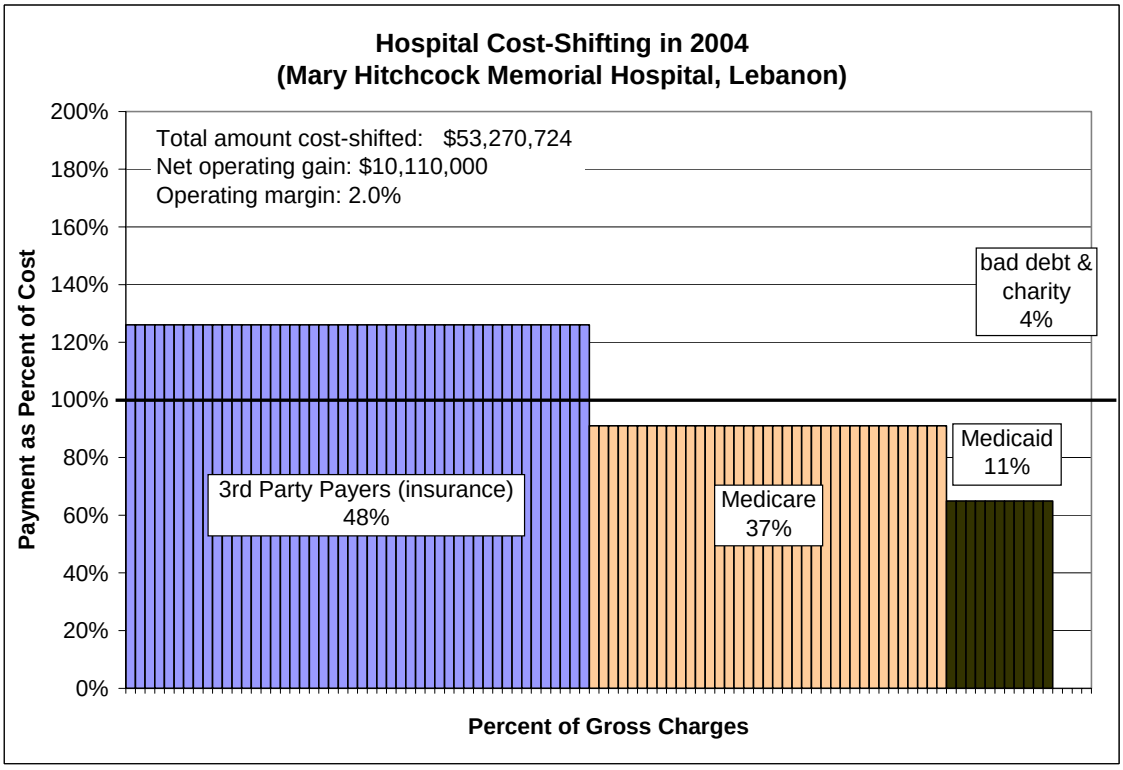
Lakes Region General Hospital, Laconia



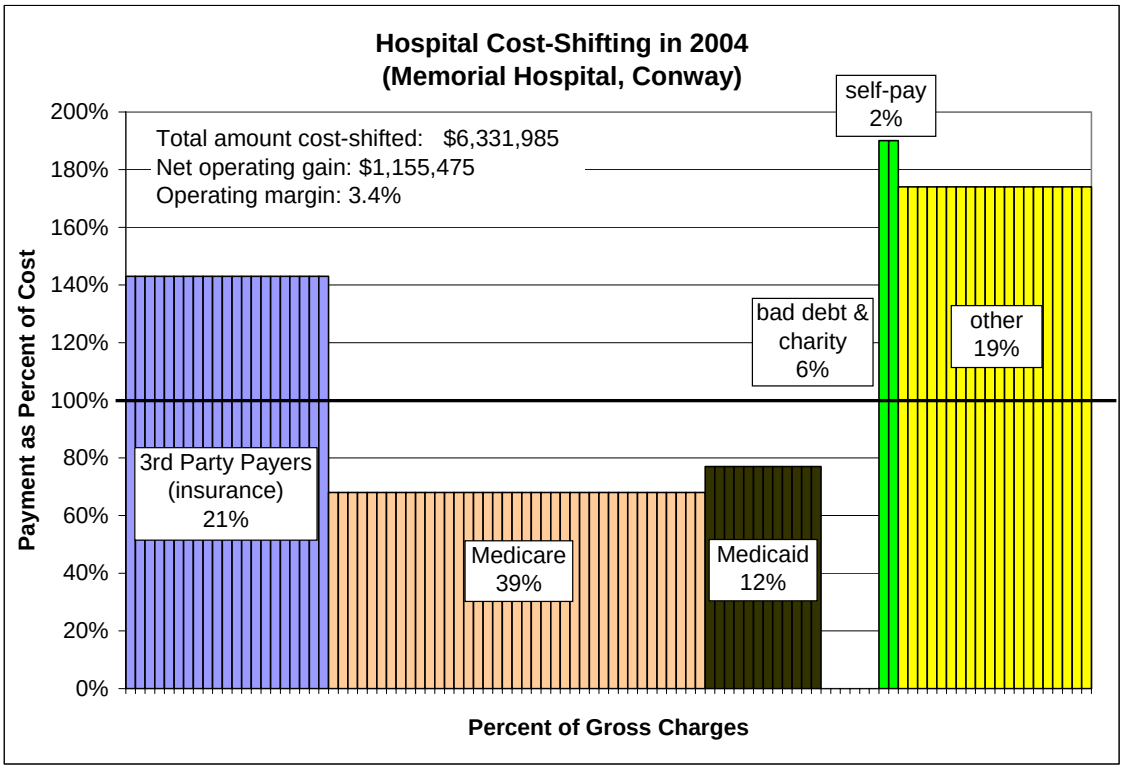
Littleton Regional Hospital



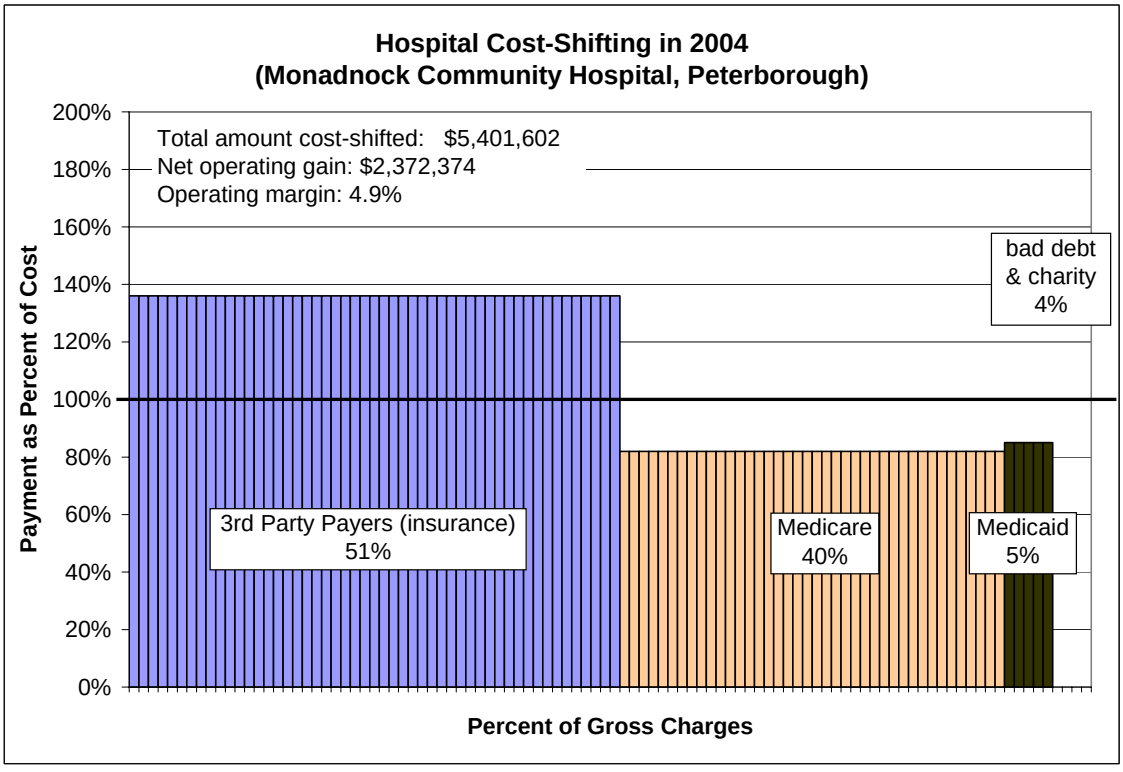
Mary Hitchcock Memorial Hospital, Lebanon



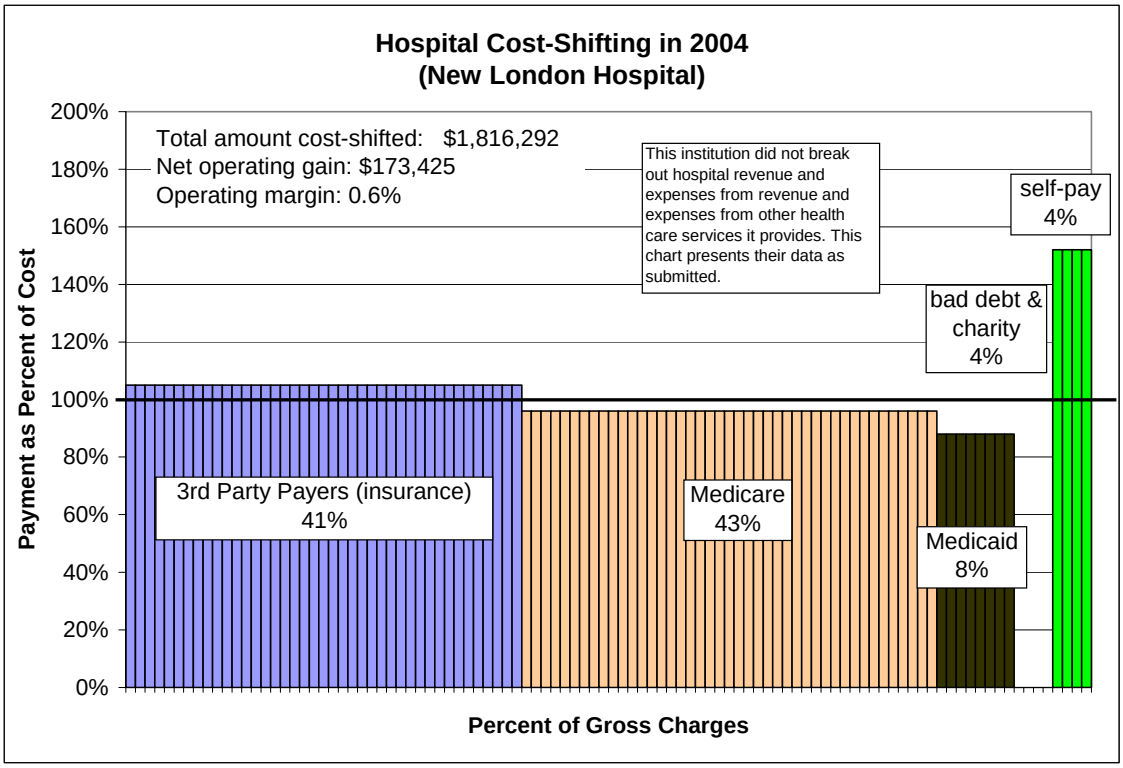
Memorial Hospital, Conway



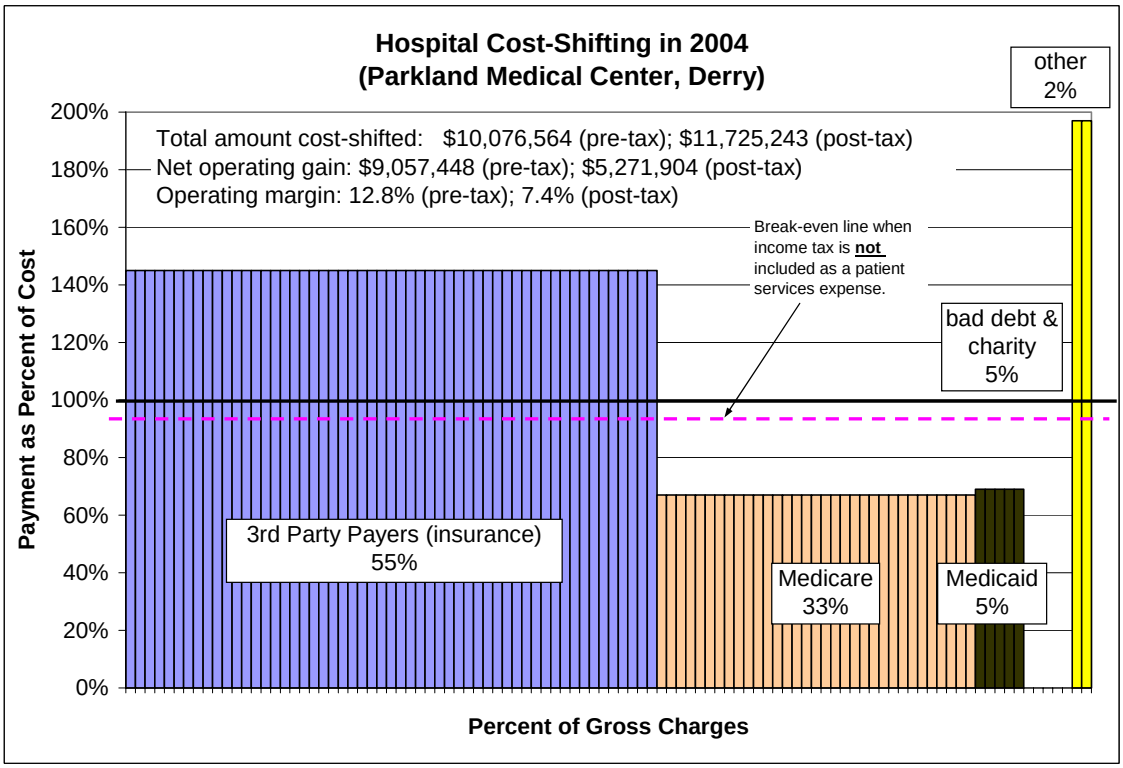
Monadnock Community Hospital, Peterborough



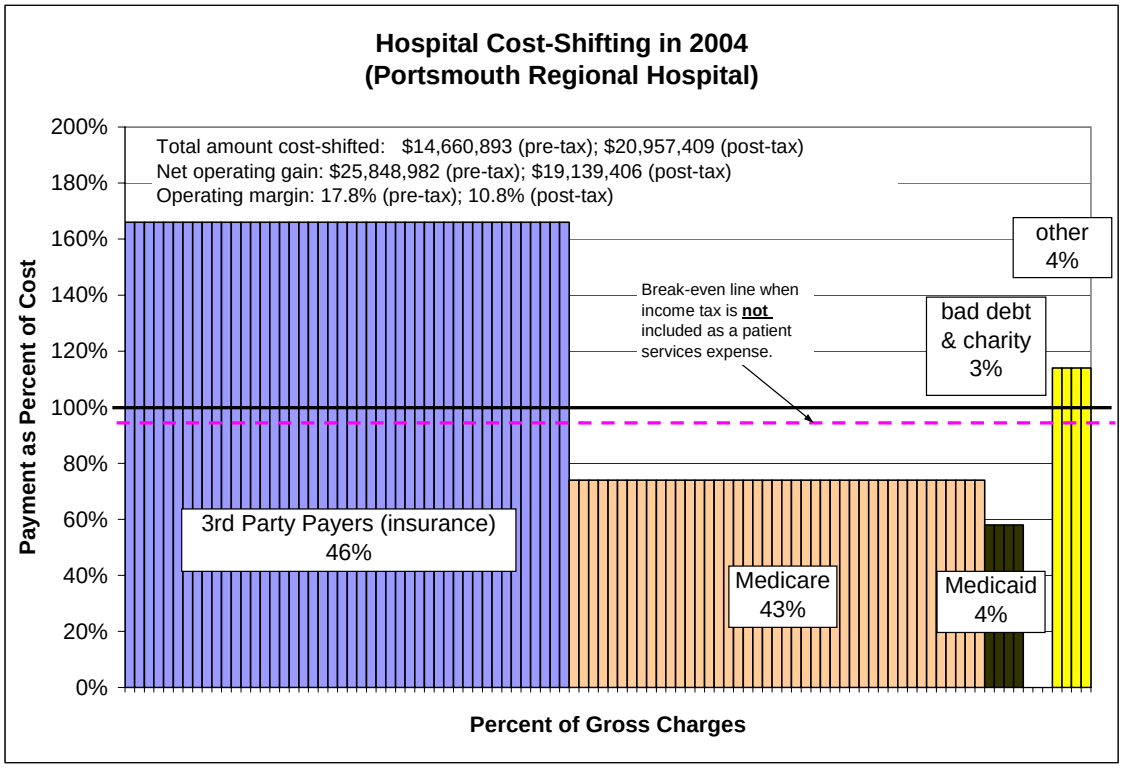
New London Hospital



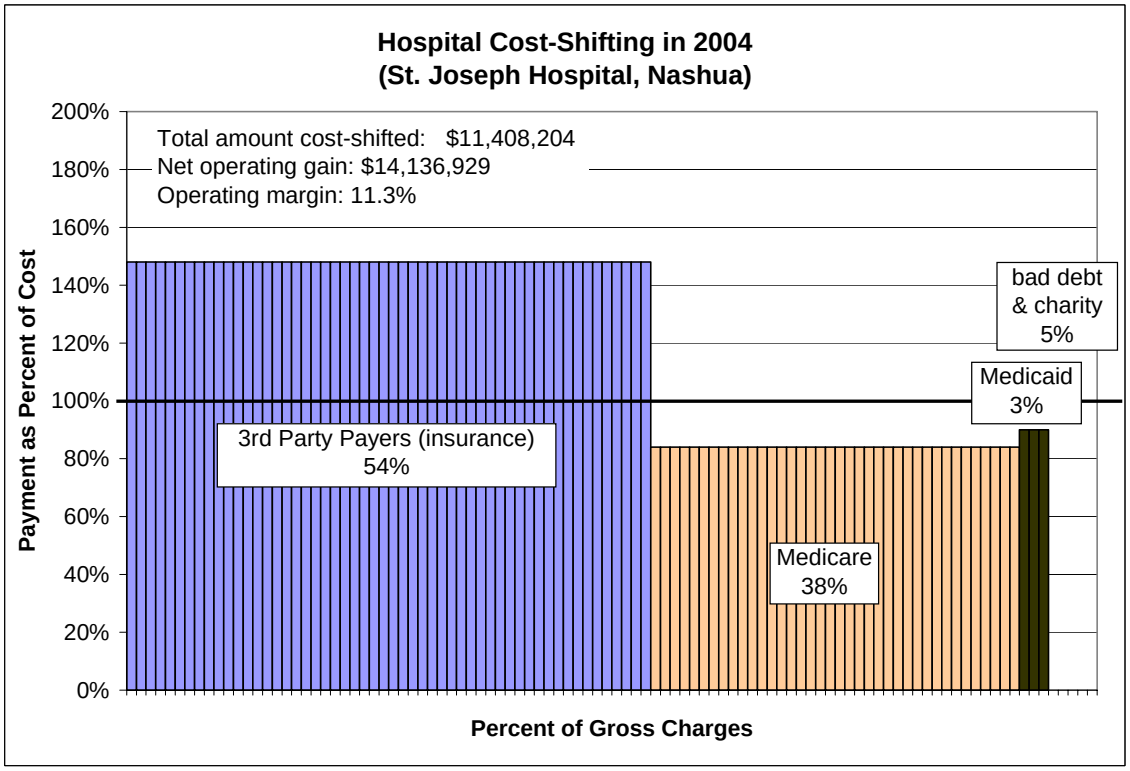
Parkland Medical Center, Derry



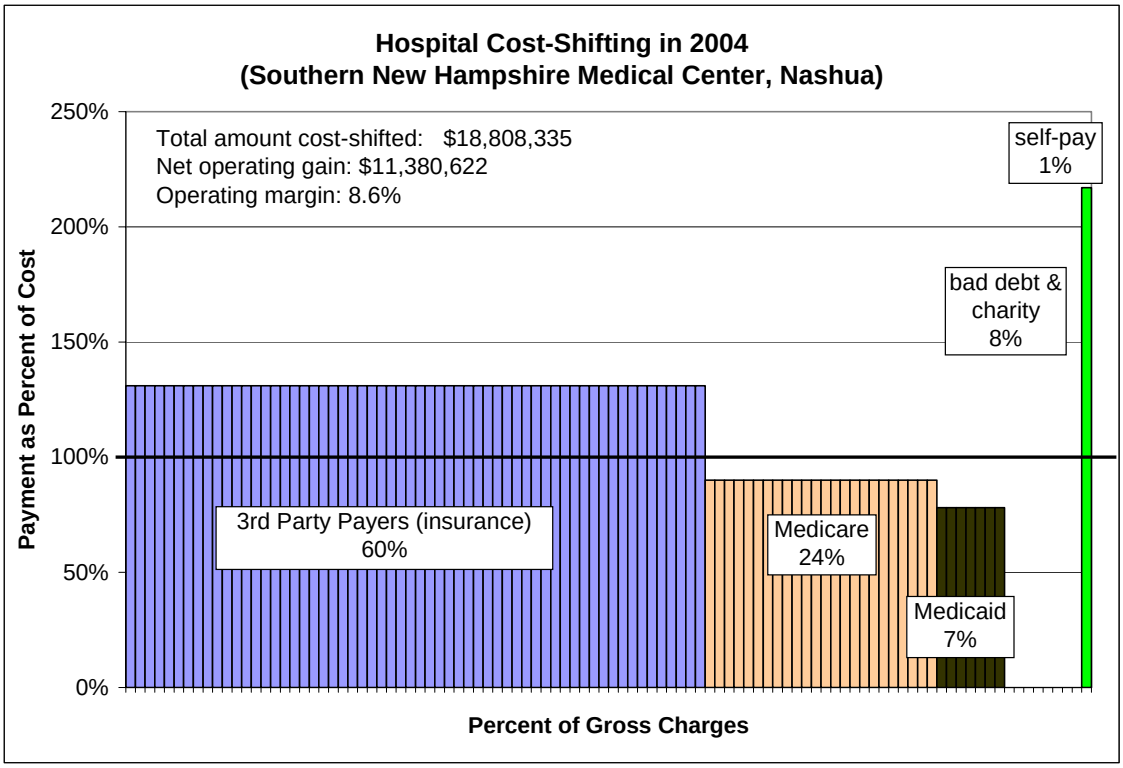
Portsmouth Regional Hospital, Portsmouth



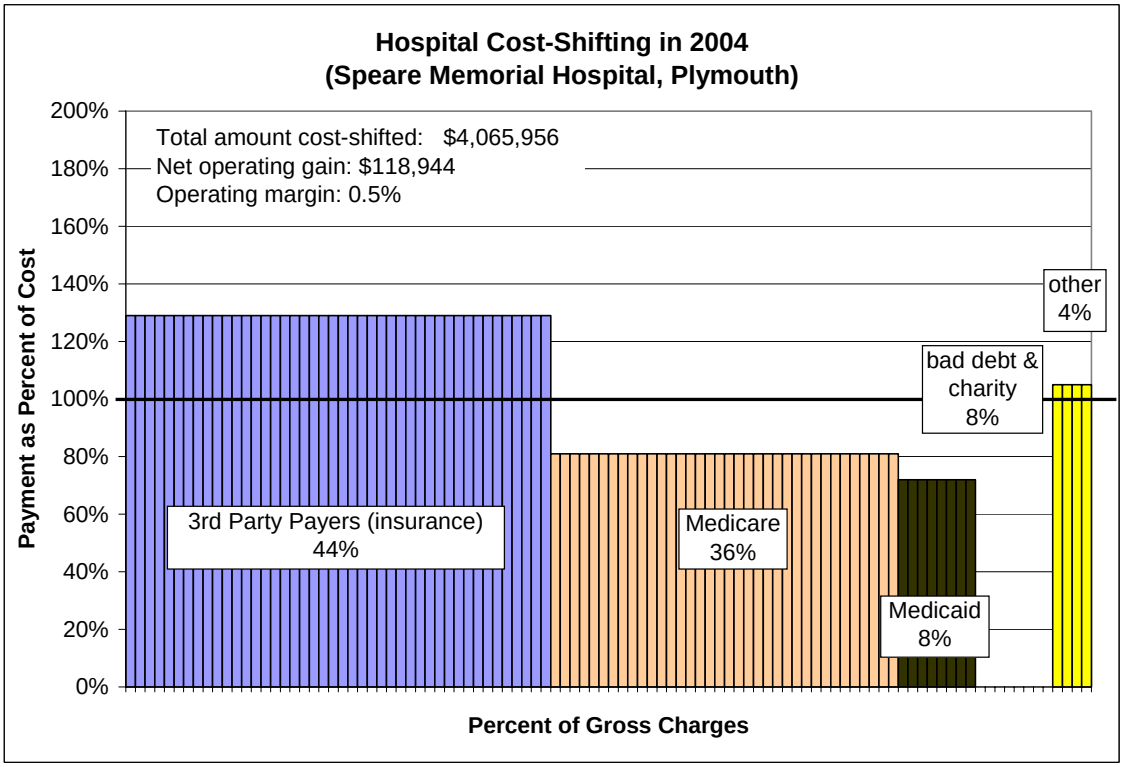
St. Joseph Hospital, Nashua



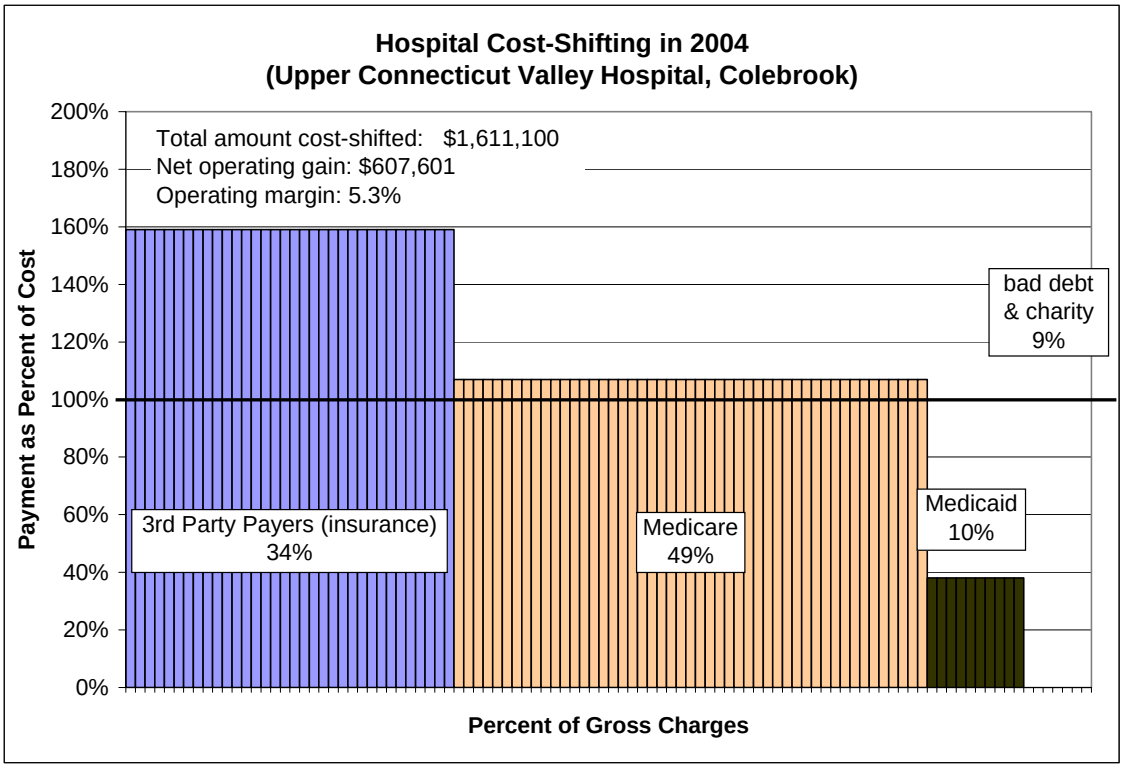
Southern New Hampshire Medical Center, Nashua



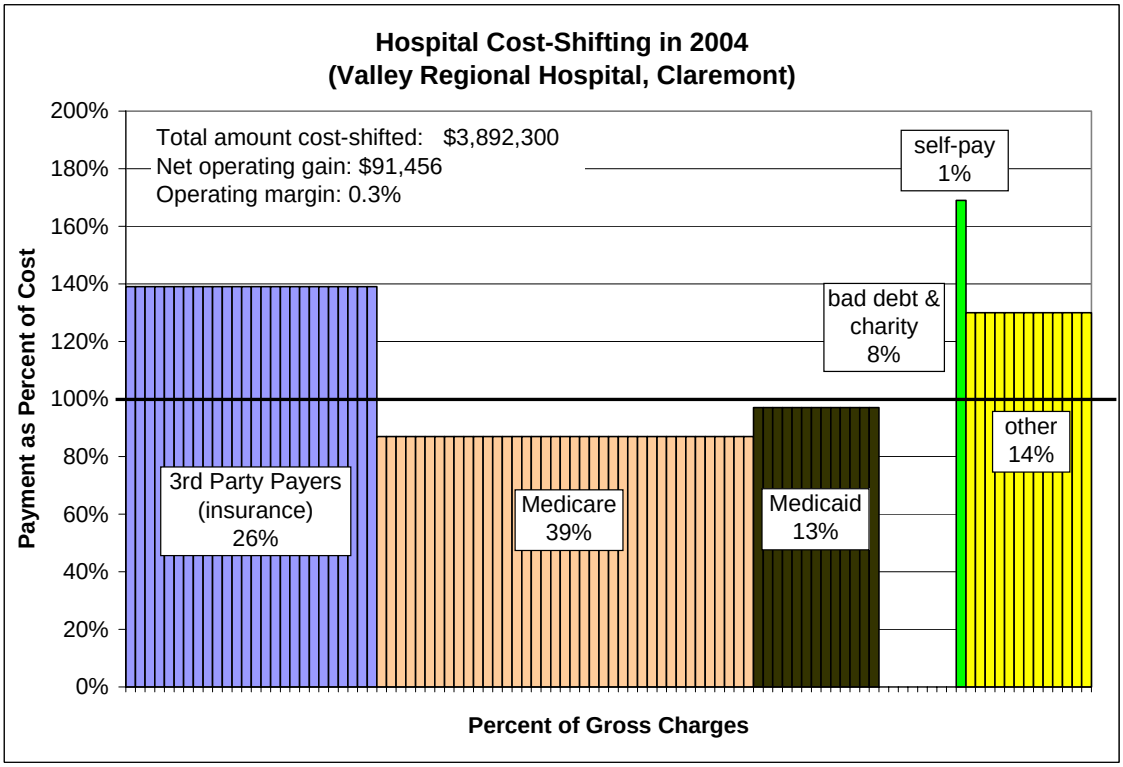
Speare Memorial Hospital, Plymouth



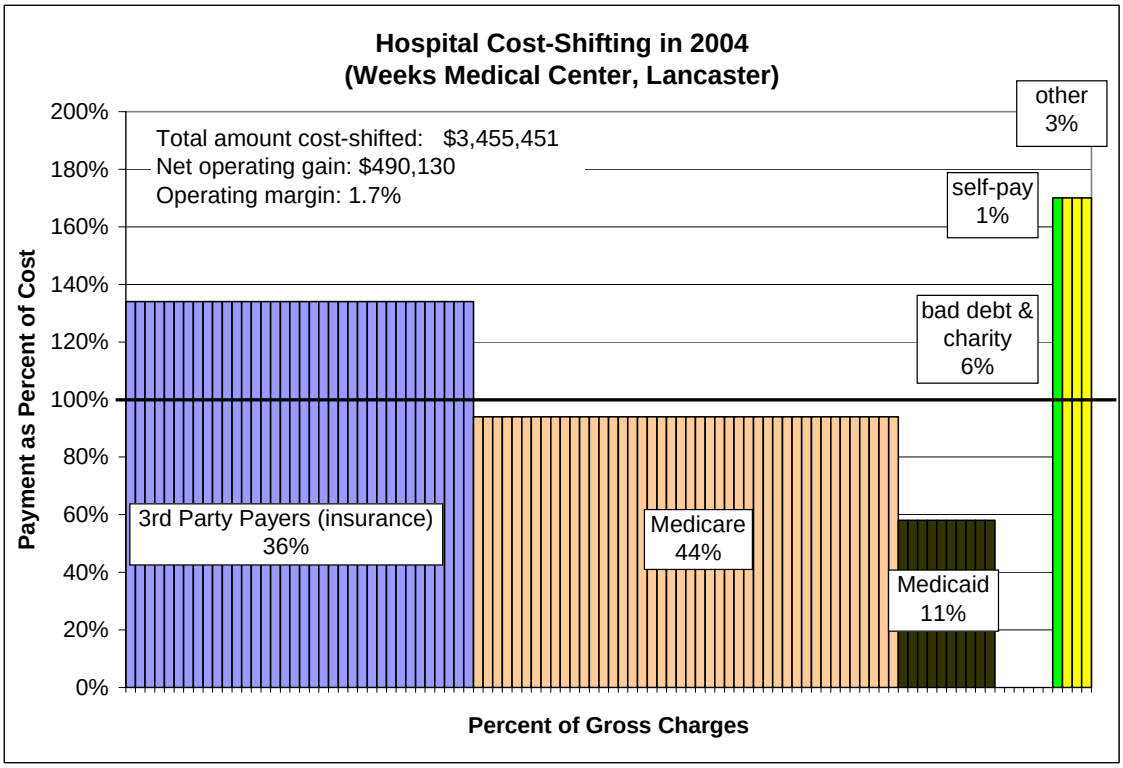
Upper Connecticut Valley Hospital, Colebrook



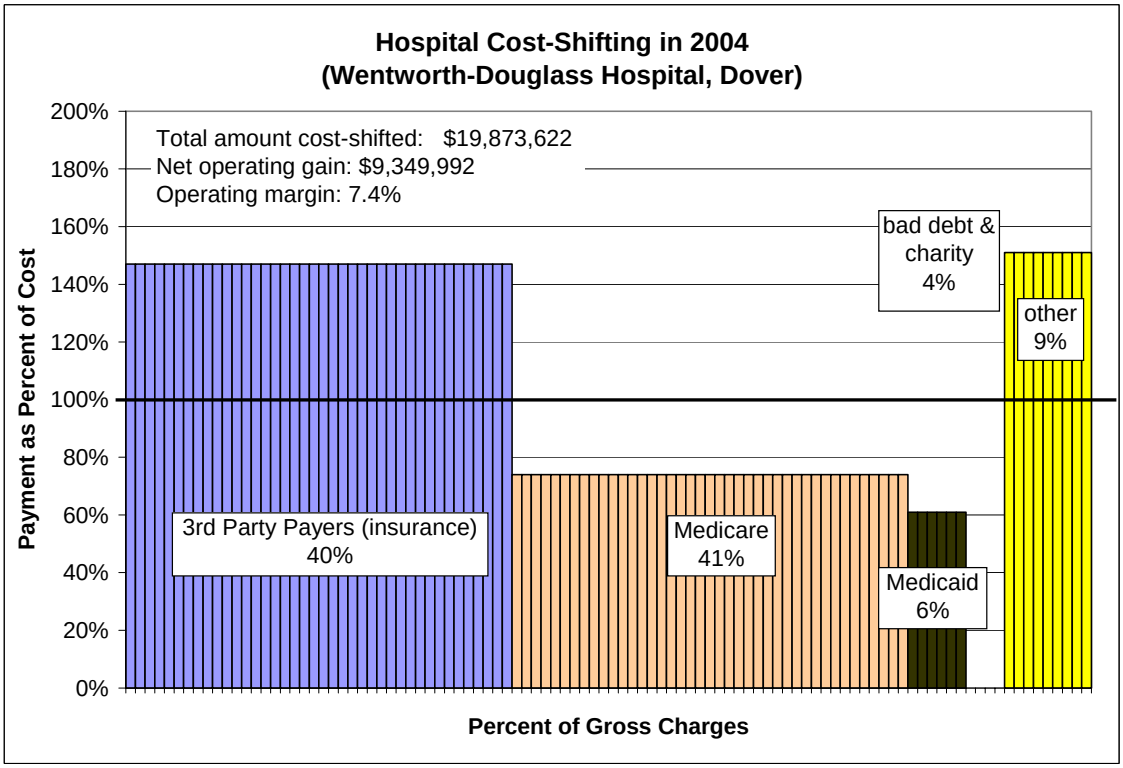
Valley Regional Hospital, Claremont



Weeks Medical Center, Lancaster



Wentworth-Douglass Hospital, Dover



Appendix B: Calculating and Charting the Cost-Shift Data

Except for our 2004 report on this topic, we are unaware of any other studies that have tried to quantify cost-shifting in hospitals and to generate hydraulics diagrams. Here we document the method we used to achieve our results so that others can understand our work and use the same or similar techniques. Our starting point was the financial data reported annually by each hospital to the NH Hospital Association in a uniform spreadsheet format.

Definitions

These definitions cite specific cells in the 2004 spreadsheet so that the hospital executives and other interested parties can verify the figures and calculations should they wish to do so.

Gross Patient Service Revenue: Charges. The aggregate list price for all patient services provided without making provision for charity care or negotiated discounts. (C64).

Net Operating Gain: The amount by which net operating revenue exceeds operating expenses including any income taxes. (C89-C97)

Net Operating Margin: Net operating income divided by net operating revenue. (C89/C75). An additional post-tax margin was calculated for the two for-profit hospitals by reducing their net operating income by the amount of tax. ((C89-C97)/C75)

Net Patient Service Revenue: The amount actually collected from all payers. Bad debt that is written off is included in this number. It is Gross Patient Service Revenue less charity care and contractual discounts. (C71).

Operating Margin (post-tax): Net Operating Income less a portion of Income Taxes that represents the proportion of Net Operating Income to Net Income Before Taxes. The result is then divided by Net Operating Revenues. Not all income tax paid is attributable to patient services when a hospital has a large Net Non-Operating Revenue (investment income, for example). This is calculated only for the two for-profit hospitals, Parkland and Portsmouth. ((C89-(C97*C89/C95))/C75)

Operating Margin (pre-tax): Net Operating Income divided by Net Operating Revenues. (C89/C75). This is an industry standard definition but it suffers from the fact that bad debt is effectively included in both numerator and denominator. Because bad debt is valued at charge, higher charges results in a lower operating margin, but only for the bad debt portion. A more stable and accurate calculation of operating margin would remove the bad debt from both numerator and denominator. We have not done so in this report so that the operating margins in this report will be comparable to those in national reports.

Total Operating Expenses: The sum of all line items that make up the expenses of hospital operation, including salaries and wages, contractual services, depreciation, supplies, utilities, etc. This includes the amount of charges that were written off as bad debt during the year. (C87).

True Net Patient Service Revenue: Net Patient Service Revenue less the amount of bad debt written off (C71-C82).

True Patient Service Expenses: Total Operating Expenses less bad debt and less an amount equal to Other Operating Revenues. (C87-C82-C73)

Step-by-Step Procedure

These steps were repeated for each hospital and also for the aggregate numbers summed across all 26 hospitals.

Step #1: Calculate "True Patient Services Expenses"
The starting number is Total Operating Expense. From this, two numbers must be subtracted.

1. Bad Debt is included in Total Operating Expense as an offset to the fact that it is also included in Net Operating Revenue. It is not actually an expense. That is, if all bills were paid at the charge amount, the stated expenses would be reduced by the amount identified as bad debt. The true amount of "checks being cut to provide services" does not include bad debt. Bad Debt is therefore subtracted from Total Operating Expense.

2. Net Operating Revenue is the sum of Net Patient Services Revenue and Other Operating Revenue. This second item may include revenue from a cafeteria, parking fees, gift shop or other ancillary functions. The expenses incurred to produce these revenues, however, are not separately identified but are included in Total Operating Expense. These ancillary functions could be net-revenue producers for the hospital or could actually cost more than the revenue they generate. We make the **assumption** that these functions are an exact break-even for each hospital, neither producing a profit nor contributing a loss. (Even if the assumption is only partly true, it has an insignificant impact on the final result because Other Operating Revenue is a very small percentage of Net Operating Revenue.) An amount of expense exactly equal to Other Operating Revenue is therefore also subtracted from Net Operating Revenue to arrive at a calculated True Patient Service Expenses.

Example:

Total Operating Expense	$46,091,717
less bad debt expense	-$2,105,430
less expenses covered by & equal to non-patient revenue	-$2,331,535
True Patient services expenses	$41,654,752

If this hospital were to obtain patient services revenue exactly equal to this calculated True Patient Service Expenses, its operating expenses will exactly equal its operating income.

3. For the two for-profit hospitals, a portion of the income tax paid must be added. The portion to be added is calculated by pro-rating the total tax between net operating income and net non-operating revenues.

Step #2: Identify Gross and Net Revenue by Payer

These data are set up in table fashion as shown in this example:

Patient Service Revenue	Gross	Net
Medicaid	$3,676,416	$1,776,388
Medicare	$29,471,250	$13,640,782
Self-Pay	$2,479,450	$1,523,668
3rd Party	$37,705,782	$29,191,718
Other	$0	$0
Total Patient Service Revenue	$73,332,898	$46,132,556

While Charity Care has been removed to arrive at the Net Self-Pay amount, Bad Debt is still included in the entries in the net revenue column of this table. Therefore to arrive at the true amount of revenue that the hospital actually received, the bad debt amount must still be subtracted.

Total (from above)	$46,132,556
less bad debt	$2,105,430
True Net Patient Services Revenue	$44,027,126

In this example, the hospital received $44,027,126 in real net patient service revenue while its True Patient services expenses were $41,654,752. Thus, this hospital had a net operating gain of $2,372,374 from patient services for the year.

Step #3: Adjust Net Self-Pay Revenue:
Self-Pay Gross Patient Services Revenue is actually made up of three components: Charity Care, Bad Debt, and Self-Pay Actually Paid.

Some Bad Debt and Charity Care are actually attributable to patients with insurance who cannot pay the deductibles or co-pays. The amount of Gross and Net Revenue for such patients is included in the "3rd Party" category in the data. While some of the Bad Debt should be subtracted from the Net Revenue for 3rd Party patients and most should be subtracted from the Net Revenue for Self-Pay patients, the necessary breakdown was not available.[16] In creating hydraulics charts for individual hospitals, we therefore subtracted all Bad Debt from Net Self-Pay Revenue.

Step #4: Calculate True Charge-to-Cost Ratio
If all patient services were paid for at the list price amount or "charges" the hospital would actually receive the amount of money it reports as Gross Patient Services Revenue. This amount divided by the True Patient Services Expenses results in a percentage. For the example, this is 176 percent. This is the True Charge-to-Cost Ratio for patient services. That is, cost was effectively marked up by 76 percent to arrive at charges. (This is an <u>average</u> mark-up. There is

[16] While this report was being prepared some hospitals did provide a breakdown of their bad debt and charity care between self-pay and insured persons. We used the result of this to estimate and present a more accurate view of the aggregate self-pay situation in the body of this report. However, to maintain a reasonable degree of comparability among hospitals, we did not do so for the individual hospital charts.

no way of determining from the available data which services may be marked up more and which marked up less than this average amount.)

(NOTE: This True Charge-to-Cost Ratio is different from and will be higher than a charge-to-cost ratio calculated by using an unadjusted Total Operating Expense in the denominator. In the example, this would be 159 percent. It can be easily seen that if all payers paid full charges the revenue received would be 176 percent of patient services expenses, not 159 percent.)

Step #5: Calculate True Cost-to-Charge Ratio
The True Cost-to-Charge Ratio is simply the inverse of the True Charge-to-Cost Ratio. For the example, this is 1/1.76 or 57 percent. That is, true cost was, on average, 57 percent of the charged amount. (This is an average. There is no way of determining from the available data which services may have a greater or lesser cost-to-charge ratio.)

Step #6: Calculate Percent of Charges for Horizontal Axis
The Gross Patient Services Revenue for each payer type is divided by the total Gross Patient Services Revenue. Self-pay revenues are divided into two categories however. Gross self-pay that is never actually paid is the total of self-pay bad debt and charity care. Gross self-pay actually paid is the amount of net revenue from self-pay. This essentially assumes that some self-pay patients pay their entire bill while the remainder pay nothing. While this is clearly not true, presenting the information this way makes the hydraulics chart easier to understand and explain. Some self-pay patients will pay the full charges and this calculation shows that.

There are 100 vertical bars on the hydraulics chart, each one representing one percent of Gross Patient Services Revenue. The number of bars for each payer type is determined by the percentages that have been calculated.

Payer	Percent
3rd Party	51%
Medicare	40%
Medicaid	5%
Self-Pay - bad debt & charity	4%
Self-Pay - actually paid	0%
Other	0%
Total	100%

The percentages are rounded. In the example, 3rd-party patients account for 51.4 percent of gross charges so they are given 51 vertical bars on the hydraulics chart.

Step #7: Calculate True Cost of Patient Services by Payer
This step is based on an important **assumption**: the average cost-to-charge ratio applies equally to all payers. Since the average cost-to-charge ratio in the example is 57 percent, that percentage is the number applied to the Gross Patient Services Revenue for each payer type to determine the cost of the services provided to that payer type.

Payer Type	Cost of Services
Medicaid	$2,088,288
Medicare	$16,740,339
Self-Pay	$1,408,384
3rd Party	$21,417,741
Other	$0
Total	$41,654,752

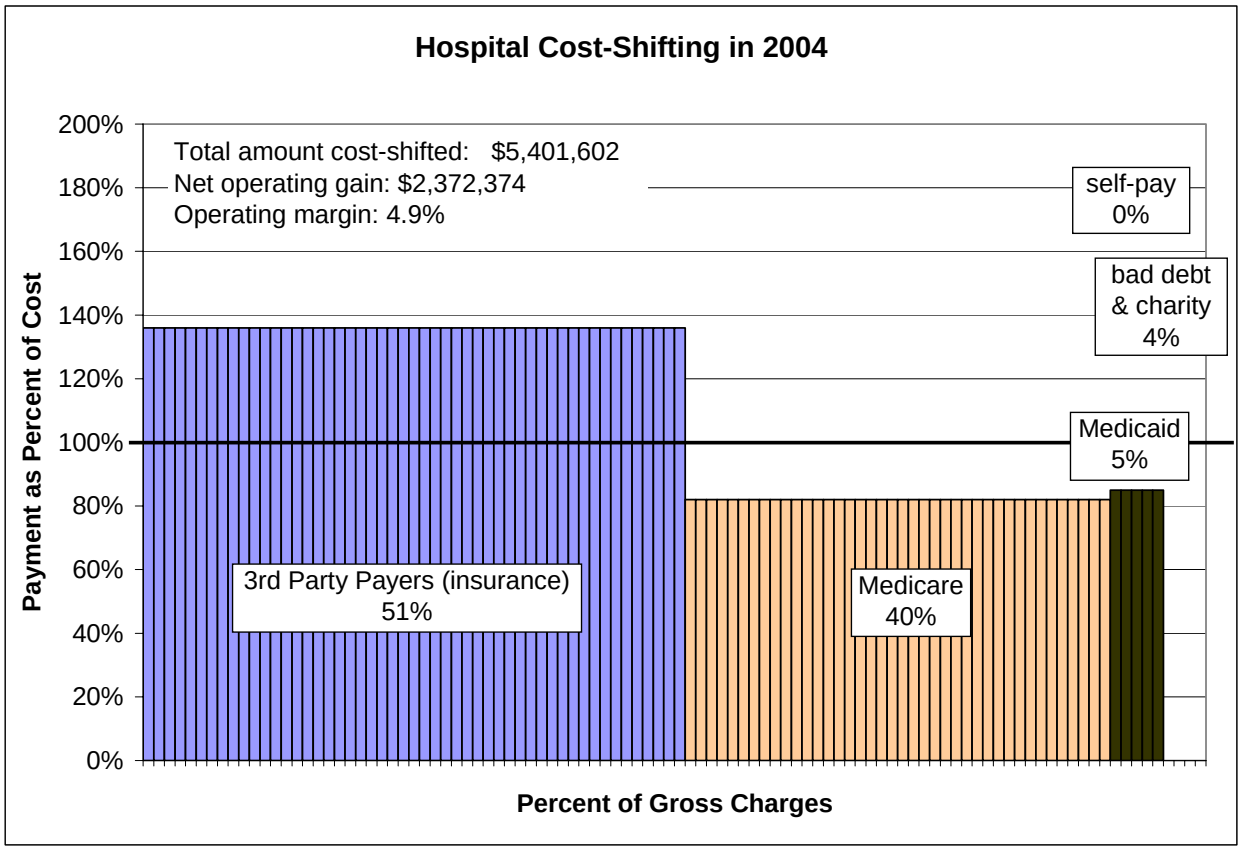
Step #8: Calculate the Percent of Cost Actually Paid for Vertical Axis
For each payer type, the ratio of its reported Net Patient Service Revenue to its share of True Patient Services Expenses is calculated. In the example, Medicare actually paid $13,640,782 and its cost of services was $16,740,339. Medicare therefore paid 81.5 percent of cost. Each of the 40 vertical bars for Medicare in the hydraulic chart will rise to 82 percent of cost.

Step #9: Calculate Difference Between True Net Revenue and Cost
For each payer type, subtract its True Patient Services Expenses from its Net Patient Service Revenue to determine the amount that payer type paid in excess of cost or in deficit of cost. The total amount cost-shifted during the year is the total of all of the deficits for those payer types that had deficits. In the example, this amounted to $5,401,602 during the year. This is the amount that had to be made up by other patient revenue sources before the hospital could "break even." In the case of the example, more than this cost-shifted amount was made up and the net operating gain for the year was $2,372,374.

To the extent that the other payers do not provide sufficient excess revenue to cover the cost-shift requirement, the hospital's patient services operated at a loss during the year.

Step #10: Plot the results
Each of the 100 vertical bars on the hydraulics chart should be plotted to rise to the height that indicates the percent of cost that payer actually paid. For example, the Medicare bars should rise to 82 percent of cost.

Graph resulting from the example hospital



Methodological Issues

There are a number of systemic problems with the hydraulics charts and the calculations used to create them. While these issues are real and affect some specific numbers, they do not diminish the utility of presenting financial data in this graphical manner, nor do they affect the overall conclusions made in this report.

1. Average Cost-to-Charge Ratio is Used

First, it is almost certainly not true that the cost-to-charge ratio is identical for each payer type. The financial data in audit reports and spreadsheets is insufficient to obtain any estimate of how that ratio might actually differ for services provided to Medicare or self-pay patients, for example. The simplifying assumption used is that the average ratio for each hospital applies equally to all payer types for that hospital. Possibly each hospital has some qualitative sense (if not quantitative measure) of the degree to which this assumption affects the result. If hospitals calculated and reported such cost-to-charge ratios for each payer type, this analysis would be more accurate.

2. Vertical Axes Cannot be Compared Between Hospitals

For any one hospital, the vertical axis is a measure of its reimbursement to its cost. Two hospitals may have quite different cost structures and thus appear to be reimbursed at quite different percentages of cost by any payer type. If hospital A is paid 140 percent of cost by insurers while hospital B is paid 125 percent, it still does not tell us which hospital is being paid more and

which is being paid less in real dollar terms. It is not possible to determine to what extent that difference is due to actual differences in payments being made for the same services versus different costs for the same service. Until some direct public measure that allows comparison of actual cost for identical services from hospital to hospital is used, the resulting charts will suffer from this deficiency.

3. Uncompensated Care is an Amalgam

If all uncompensated care were provided to self-pay patients only then subtracting the bad debt and charity care from the gross self-pay revenue would result in the net self-pay revenue. Yet it is clear that this is not the case. Some undetermined portion of reported uncompensated care is not attributable to self-pay patients but (probably) to insured patients who cannot or do not pay their deductibles or co-pays.

This means that the ability to split the self-pay category into two components for the graphs is not possible. The fully-paying self-pay category may be zero or even less in the calculations because the uncompensated care total exceeds Gross Self-Pay Revenue. The example used above is a case in point. Since the total uncompensated care actually exceeds the gross self-pay revenue, there is no vertical bar on the horizontal axis for fully-paying self-pay patients.

We recommend and are very hopeful that all hospitals will begin to report charity care and bad debt write-offs separately for self-pay and insured patients.

While this report was being prepared, we engaged in a preliminary effort to gather this information from all hospitals. That effort was successful but not complete. We used the results to make overall estimates but did not incorporate the incomplete results into the charts for individual hospitals. When all hospitals report uncompensated care as we suggest they should, this issue will be resolved.

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